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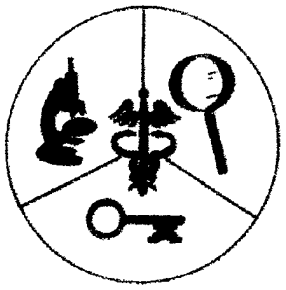

CENTER FOR
HEALTHCARE EDUCATION
AND STUDIES

RESERVE COMPONENT 746 STUDY

By

CONTRACTOR: SRA International, Inc.

Contract Study

CAAS 98-003

22 June 1998

UNITED STATES ARMY
MEDICAL DEPARTMENT CENTER AND SCHOOL
FORT SAM HOUSTON, TEXAS 78234-6100

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UNITED STATES ARMY
MEDICAL COMMAND

ARMY
MEDICINE

CARING BEYOND THE CALL OF DUTY

RESERVE COMPONENT
746 STUDY

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INTERNATIONAL, INC.

Reserve Component 746 Study

Contracted by

United States Army Medical Command

Prepared by

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1777 N.E. Loop 410
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Under Contract Number DADA10-96-D-0022
Report Delivery Date: June 22, 1998

RESERVE COMPONENT 746 STUDY REPORT

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EXECUTIVE SUMMARY

During the Desert Shield/Storm deployment, there were significant numbers of Reserve Component members found to be non-deployable for medical reasons. In addition, the downsizing of all components over the past several years has significantly reduced the Reserve Component medical structure presently providing medical readiness support. The Army Surgeon General, via the United States Army Medical Command, directed a survey of the present methods of providing medical readiness support to the Reserve Components and other potential providers and options. The study objective is to recommend the best three options. This report provides the results of that study.

Through information received from databases, written surveys and direct interviews, four key elements surfaced regarding the provision of medical readiness support. Specifically, they are:

- The differences in the missions, medical support resources, and perspectives of the ARNG and the USAR,
- The cost of medical readiness support,
- The accessibility of the medical support provider to customer RC unit members, and
- The option to provide medical support during the weekday.

Each key element will be discussed briefly below.

Differences in the missions, medical support resources, and perspectives of the ARNG and the USAR.

For the Army National Guard a combination of organic medical unit personnel and medical detachment staff provides the support. The TDA medical detachments are authorized personnel and equipment specifically to provide medical readiness support to their units. The medical detachment is part of the STARC and does not have a direct federal WARTRACE medical mission as found with USAR TDA medical units. Presently, 50 percent of the states have operational medical detachments providing medical readiness support to their units. The remaining are programmed to be operational by December 1999. This program will generate a nationwide medical readiness support system for the ARNG that includes staff, equipment and facilities. No similar system exists in the USAR.

The USAR medical personnel providing support are members of both TDA and MTOE units. There are additional reductions planned in medical MTOE and TDA strength for the USAR, which will further reduce the availability of medical readiness support for units. The USAR has the majority of medical assets in the Reserve Component with a Federal mission. These units all have a mobilization mission. USAR TDA units are WARTRACE aligned with the US Army Medical Command (MEDCOM), and so are not authorized medical equipment. The MTOE equipment is not suitable for the monthly provision of medical readiness support. The majority of USAR medical units provide medical readiness support through the use of Active Component Medical Treatment Facilities (MTFs), Department of Veterans Affairs facilities, or other facilities with the needed equipment. In contrast to the ARNG, the USAR use "borrowed" manpower from its medical units and relies on other agencies for facilities and equipment to provide medical readiness support.

Senior members of the ARNG and USAR have expressed concern that Reserve medical units, especially MTOE units, are tasked to provide medical readiness support. Rather, limited available weekend training time should be used for mobilization mission task training. Both Reserve Component providers reported unusually high "no-show" rates: ARNG 10-15 percent, USAR 40-50 percent. The no-show rates are based on soldiers scheduled by their unit full-time staff for a physical examination or other medical readiness support who fail to report as scheduled. This is a waste of medical support assets and frustrating to RC Units providing the support.

Cost of the medical readiness support.

Cost accounting methodologies vary among potential providers. The Active Component uses the MEPRS system or the DOD Reimbursable Rate schedule. Historically, there has not been a comparable standard budgeting and accounting system within the Reserve Components. The ARNG and USAR are presently programming the costs of medical readiness requirements using a combination of CHAMPUS Maximum Allowable Charge (CMAC) rates, existing DOD contractual costs (such as TSRDIP and HIV testing), and national prevailing fees charged by private sector providers. Discounted CMAC rates are normally expected from potential civilian contractors when bidding on contract proposals. The costs quoted by two civilian contractors, not based on CMAC rates, were also included in the study. The Department of Veterans Affairs would likewise use discounted CMAC rates to establish the costs for providing medical readiness

services under a sharing agreement with the Department of Defense. After considering these and other sources of cost data, the study shows that accomplishing these medical readiness requirements is the least costly when done with AC and RC assets. The second least costly would be the Department of Veterans Affairs at a 15 percent discount of CMAC rates. Third would be civilian contractors at a 10 percent discount of the CMAC rates. The fifteen and ten percent discounts were selected for study purposes after discussions with DVA officials and civilian contractors. Most potential providers, including the DVA, are reluctant to discuss firm costs for which they might provide the required examinations and test.

Accessibility of the medical support provider to the customer RC unit member or individual.

From a "customer" perspective the availability of and access to needed medical readiness support is critical. Our study shows that the DVA and Continuum Healthcare have support site accessibility, within 75 miles, to over 95 percent of all RC units. Under the RC provider network, 45 of 103 RC provider units reported that they provide support to personnel who have traveled 200 miles or more one way to receive medical readiness support. Additional USAR medical force reductions will exacerbate the problem. This is expensive in terms of travel costs. and is a loss in training time for RC provider units and customer units. The DVA and Continuum Healthcare appear to be excellent sources of medical readiness support based on accessibility.

The possible option to provide medical support during the weekday.

The possibility of weekday support surfaced during discussions of sources of medical readiness support outside the RC provider system. This perspective of support affects several other study areas. First, a policy change would be necessary to allow the use of fragmentary annual training, to receive individual medical readiness support during the week. The use of an AT day should ease potential problems with employers. Greater flexibility in scheduling the support (20 available days per month instead of 8) should easily resolve most employer conflicts. Secondly, the fragmentary annual training and minimal travel costs (if a highly accessible provider were contracted) would require funding. Note that the shifting of support to weekdays would be to take advantage of a more geographically available and cost effective provider. So other savings may outweigh these costs. **The pursuit of this option requires extra**

initial effort but the overall benefits to the Reserve Components medical readiness support could be greatly enhanced in several areas. This option has several advantages over the existing weekend program:

- The effective daily workload is reduced by a potential factor of 2.5 regardless of the provider used. The fixed workload is spread over 20 potential days of support per month as compared to only 8 potential day per month during the weekend.
- The reserve provider units are removed from the equation and may train to their wartime mission during weekend drill. Physician retention rates may improve.
- RC personnel will not miss drill to receive medical readiness support.

The 746 Study Matrix

The 746 Study Matrix presents the organizations considered to be potential providers of medical readiness support in comparison with the six evaluation criteria:

- Accessibility: Accessibility of medical readiness support sites to RC unit locations.
- Cost: Relative costs for the provision of medical readiness support.
- System Impact: Impact on RC providers from providing medical support.
- Lost Training Time: Loss of training time while obtaining medical readiness support.
- Other Costs: Costs sustained by RC provider/customer associated with medical support.
- Expansion: Ability for current providers to expand support.

Note that the provider columns are subdivided into two columns representing weekday and weekend medical readiness support.

The blocks representing the relative ability of a particular provider to satisfy evaluation criteria are colored to indicate the degree of satisfaction.

- Dark Blue = strong positive
- Dark Green = strong
- Yellow = middle, neutral; others above and below
- Pink = negative
- Red = strong negative

Table ES-1 RC 746 Study Matrix

RANKING	PROVIDER / WEEKDAY/WEEKEND	ARNG WD	ARNG WE	USAR WD	USAR WE	MTF WD	MTF WE	MEPS WD	MEPS WE	ORK WD	ORK WE	DVA WD	DVA WE	CONTI WD	CONTI WE
						++		++		++		++		++	
1	ACCESSIBILITY														
2	COST							??							
3	SYSTEM IMPACT														
4	LOST TRAINING TIME														
5	OTHER COSTS	??		??											
6	EXPANSION					??	??								

= Strong Positive
= Positive
= Neutral or Middle Impact; Some Higher, Some Lower
= Negative
= Strong Negative
= Not a Reasonable Option or Not Applicable
?? = Unknown
++ = Requires an Extra AT Day and the Corresponding Funding Support

The SRA 746 Team listed the provider assessment criteria in the order (Ranking column), in their opinion, that has the greatest significance in the delivery of medical readiness support; other readers may elect to alter the order.

Study Recommendations:

Scope of the Recommendation. The SRA 746 team is aware of related ongoing studies being led by DOD (HA) and (RA). Even though this study focuses on the Reserve Components of the Army, the SRA Team and the MEDCOM contract representatives recognize that there are at least three other perspectives that could be considered:

- A DOD wide perspective supported by DODMERB for total program uniformity, centralized budgeting, and consistency among the services,
- A DA wide perspective, to consider medical readiness support for both Reserve Components via a "blanket" Army program, and
- An Army plan that considers each Reserve Component independently based on its existing situation and resources.

The overall SRA 746 Team's recommendation can be adapted to any of these levels/degrees. The system changes necessary to support the recommendation must also be adapted to the appropriate level. For example, an evaluation of the existing clinical requirements should be accomplished at the highest level for consistency. The level/degree of effort will also

dictate the responsible agencies for implementation and administration of the program. There are others that are beyond the scope of this study.

The SRA Team recommends the following system changes:

- Funding for medical readiness support to all service medical components should be centrally budgeted, distributed, and controlled. Further, capture the specific funding aspects for the RC medical readiness requirements for future program adjustments.
- A clinical panel should review the procedures and requirements currently in AR 40-501. The approved protocol for physical examinations and other medical readiness requirements should be made mandatory and consistent for all Reserve Components of the Army or DOD wide.
- RC Commanders must be responsible for ensuring that their unit personnel report for medical readiness support as scheduled, regardless of the source of support.
- Charge the AGR staff of the Regional Medical Command with the initial coordination and maintenance of the program for the Army.
- Document the current DODMERB program so that it can serve as a benchmark. Special consideration should be given to the Quality Assurance program, the extensive guidance provided to the direct care contract provider, and the advantage of having a single source provider for consistency, contract simplicity, singularity of guidance, and continuity of effort.
- Initiate efforts to change Title X, US Code to eliminate the periodic physical examination requirements for members under 30 years of age. The Active Component made this change in March of 1998. The standards for medical readiness requirements should be the same for all Components.

Recommendations.

The following, in order, are the SRA Team's recommendations for the three best systems for supporting RC medical readiness requirements.

1. A conservative approach that addresses the most serious concerns and requires the minimum program change. This pilot program, would leave the ARNG system unaffected at

present, remove responsibility for USAR medical support, and institute the following program for the USAR only:

- Medical readiness requirements to be satisfied during the week via Fragmentary annual training, for all members of the Ready Reserve.
- Provision of medical readiness support contracted to the Department of Veterans Affairs because its prices are among the most competitive, its locations are highly accessible to RC units and its facilities are already equipped and able to provide the full range of needed medical readiness support services. Further, its nationwide administrative infrastructure is in place, the DVA is interested in this mission, and the Department has experience working with RC via some existing contracts.

When the pilot program has been in place long enough to generate sufficient program history, evaluate the ARNG and "new" USAR programs with respect to cost efficiency and ability to support, then make any necessary adjustments.

2. An Army-wide approach that addresses the overall concerns and provides the best solution to the provision of medical readiness support to the RC of the Army. This option removes all RC providers *and does not consider the state and community aspects of the current ARNG program.* This approach includes weekday medical readiness support provided by the Department of Veterans Affairs for the ARNG and the USAR. This initiative eliminates the need for peacetime resourcing of medical personnel, equipment and facilities within the Reserve Components. Being an "Army only" initiative, an RMC wide implementation program with the medical staff from the area STARCs, RSCs, DVA supporting regions, is necessary. The MEDCOM RMC must take the lead. Initial implementation could start as a pilot program in one RMC.

3. A DOD-level initiative, involving the Reserve Component Elements of all the services. This option represents the most comprehensive program and the most difficult to implement. Being a joint undertaking, the DOD regions would have the lead, working with each Service medical element and each RC element within each service. This option does provide singularity in funding, procedural protocols, quality assurance, and direction. This initiative would require a major effort, but would be worth it in the long run. This approach might be viewed as the final step in an evolutionary process.

SECTION 1. INTRODUCTION

The most recent major mobilization of the Reserve Components during Desert Shield-Desert Storm in 1990-91 uncovered a significant number of Reserve Component members found to be medically non-deployable. The regulatory responsibility for the provision of military readiness support is with the United Stated Army Medical Command (MEDCOM). The MEDCOM, and Health Services Command prior, has been unable to provide the necessary support due to the wide dispersion of Reserve Component units throughout the country and the relatively few medical treatment facilities. Out of necessity and by default, the Reserve Components have taken on the medical readiness support mission with their own medical resources. The ARNG and USAR medical structure consists of a combination of Modified Table of Organization and Equipment (MTOE) or Table of Distribution and Allowances (TDA) units. The missions of these medical units range widely but were not designed to provide medical readiness support.

The size of the armed forces of the United States has been greatly reduced over the past several years through downsizing efforts following the economic and political downfall of the Soviet Union. The dependence of the active force on immediate augmentation from the Reserve Component is evident. With the general downsizing of all components of the force comes the corresponding reduction in medical structure both in numbers of medical units and of locations providing medical readiness support. The ability of the Reserve Component forces to continue to provide the needed medical support in the same fashion as before is suspect.

Reserve Component leaders have voiced for years that all Reserve Component medical units, but *especially MTOE units* with a theater support mission, should be using the limited weekend training time to train to wartime mission requirements rather than to provide medical readiness support to other reserve units.

The United States Army Surgeon General, via the United States Army Medical Command, has requested a study to evaluate the current system, consider other possible provider options, and make three ranked recommendations for the best method of providing medical readiness support to the Reserve Components of the Army. Factors such as cost, efficiency, and provider system impact on the Reserve Component will be included in the study.

This study is limited to the Reserve Components of the United States Army, specifically the Army National Guard Component, COMPO 2, and the United States Army Reserve, COMPO 3. This study will concentrate on Reservists serving in troop program units but will allow for the support of all members of the Ready Reserve. Those Reserve Component members requiring medical readiness support will be frequently referred to in this report as the "customers". Reserve Component units (medical) currently providing medical readiness support, along with potential medical organizations within and outside of the Federal Government, will be referred to as "providers". The mission, methods and resources currently used by the ARNG and the USAR differ widely. These differences in components will require individual consideration with regards to certain factors.

SECTION 2. METHODOLOGY

The initial study direction consisted of three principal components: System Cost, System Effectiveness, and Unit Effectiveness. These major areas were further subdivided into six specific areas for consideration: cost of examinations, accessibility (of provider), expansion capability (existing providers), impact on RC provider units, impact on RC customer units, and additional costs. During the course of the study, additional criteria surfaced through non-structured comments during personal interviews and through "additional remarks" in the written surveys. Most of these additional criteria areas in and of themselves would not influence a specific decision or recommended outcome. However, when taken collectively, they demand surfacing in this report. Some concerns expressed may be regional in nature and not indicative of the entire system. The remainder of this section discusses the process of information gathering and the organization of the study.

2.1 Information/Data Collection

Data collection proceeded primarily along two avenues: written surveys and personal interviews. Both methods were preceded by an introduction in the form of a letter requesting support and cooperation in the study effort. These letters were issued by OTSG, via MEDCOM, with a GO signature and were sent to the potential providers inside and outside DOD.

Surveys, an example of which appears in Appendix C, were developed for the following organizations:

- USAR provider units, distributed through the USAR RSC surgeons office,
- ARNG provider units, distributed through the STARC surgeons office, and
- MEDCOM MTFs, distributed through the Regional Medical Command.

The SRA Team scheduled interviews in five regions of the country with RSC and area STARC medical staffs. The interviews contained four structured questions with multiple parts and a non-structured discussion in the following areas: "What is working, What is not, and Why?", "What fix is needed, If any?", and "Out of the box solutions?"

The locations below were selected to provide a representative sample of information and perspectives.

- 99th RSC, Oakdale, PA and the Pennsylvania STARC, Indiantown Gap, PA
- 89th RSC, Wichita, KS and the Kansas STARC, Topeka, KS
- 81st RSC, Birmingham, AL and Alabama STARC, Montgomery, AL
- 96th RSC, Salt Lake City, UT and the Utah STARC, Draper, UT
- 70th Regional Support Command, and the Washington STARC, Tacoma–Seattle, WA
- 807th Medical Brigade (USAR), Segoville, TX

The SRA team also contacted officials from the following organizations to gain information such as costs, provider location, and other medical readiness support issues.

Department of Veterans Affairs (DVA)
Office of the Army Surgeon General (OTSG)
Department of Defense Medical Evaluation Review Board (DODMERB)
ORKAND Corporation (DODMERB Contractor)
Foundation Health Federal Services
Brooke Army Medical Center (BAMC) Staff elements
United States Army Medical Command (MEDCOM) Staff elements
United States Army Dental Command (DENCOM)
National Guard Bureau (NGB)
United States Army Reserve Command (USARC)
TRICARE
Office, Chief Army Reserve
Continuum Healthcare
Defense Manpower Data Center
Department of Health and Human Services

2.2 The Study Focus

This study focused on potential providers of medical readiness support to the Reserve Components with respect to the following six criteria: cost, accessibility (to medical support site), expansion capability (of current providers), impact on the provider system, loss of training

time, and other costs. The SRA study group concentrated the first two study criteria elements – cost and accessibility – yet integrated other elements as they appeared.

2.2.1 Provider Systems. Potential providers contacted for the study are listed in table 2-1 with details of their participation or non-participation. The Team supplied a copy of the Medical Readiness Requirement profiles, appropriate extracts from Army Regulation 40-501, Standard Forms 88 and 93. and the required Health Risk Appraisal forms to each non–DoD provider and requested a description of their provider network by zip code, the services their system could provide, and a cost for each service. A copy of correspondence sent to these providers is contained in the supporting Working Papers to this study.

For the purpose of this study, the medical readiness elements are considered to include at least the following components: physical examinations, dental examinations, eye examinations, immunizations, and HIV testing.

Table 2-1 Potential Providers' Status

Potential Providers	Available Services	Reason for Non-Participation
Active Component Medical and Dental Treatment Facilities	All	
The Reserve Component Medical and Dental Examining Sites	All	
The Military Entrance Processing Command.	Unknown	No response received
The Department of Defense Medical Examination Review Board. (DODMERB).	All by contract. if given mission	No mission
The Department of Veterans Affairs.	All	
The TRICARE Management Activity. Aurora. Colorado.	None	No mission
Humana Military Healthcare Services. Inc.. Louisville. KY.	Unknown	No response received
Foundation Health Federal Services. San Antonio. TX.	Unknown	No response received
Aetna. US Healthcare. Inc.. Blue Bell. PA.	None	No strategic business interest
PACIFICARE. Inc. San Antonio. TX.	None	Insufficient provider network
ORKAND Corporation. Falls Church. VA. (Current contractor for DODMERB).	All	
Continuum Healthcare. Inc.. Atlanta. Ga. (Selected for extensive provider network).	*	
Private physicians billing the USAMEDCOM for physical examination services.	**	

*The corporation is currently establishing a network to provide dental services.

**Although not representing a "system". the billings on file in the US Army MEDCOM Finance and Accounting Office. from private physicians for performing physical examinations. were reviewed and recorded for comparison to other sources.

2.2.2 Determination of Costs. Costs for the medical readiness requirements were derived based on information from the following sources:

- The Department of Defense Medical Expense and Performance Reporting System (MEPRS), FY 98 data available May 98.

- The FY 1998 Department of Defense Reimbursable Rates from the Office of the Under Secretary of Defense Memorandum, dated 26 September 1997.
- CHAMPUS Maximum Allowable Charges as of February 1, 1998.
- Survey data submitted by Reserve Components.
- Program data obtained from the Reserve Components.
- Quotations from potential sources outside the Department of Defense.
- Fee schedules for various dental providers (United Concordia, Delta Dental, TSRDIP, Mutual of Omaha Dental Plans, etc.).
- The Federal Supply Catalog
- Defense Department contracts for HIV testing
- Review of physician billings to the US Army MEDCOM for various examinations and testing.
- Dental Economics Magazine, May 1997. (1998 Survey not available until December issue).

2.2.3 Determination of Accessibility. Accessibility, from the standpoint of this study, is a comparison of the distance traveled by a customer to receive medical readiness support. The study determination was made through the use of zip codes. Provider databases with zip codes and customer zip codes were plotted. All provider sites were imposed onto a plot of ARNG unit only, USAR units only, and a composite of all RC units. Non RC providers provided their databases directly. The RC provider sites were requested via a written survey sent to all RSC and STARC surgeons' offices, for further distribution to the medical units in their command providing medical readiness support. RC unit databases were requested and received from the National Guard Bureau and the United States Army Reserve Command. Since all ARNG and USAR units did not respond to the survey, the RC provider accessibility percentages may be somewhat lower than actual. ARNG provider "umbrellas" may include units from other states, giving a higher than actual percentage. The provider zip codes were adjusted to display a 75-mile radius from the zip code center. The 75-mile radius was selected since in most cases a RC soldier should be able to reach the medical support site in two hours. This would make the soldiers available at a site by 8:00 A.M. if they left not before 6:00 A.M. The provider "umbrella" is shown in yellow on the plots at Appendix A.

2.2.4 Determination of Expansion Capability. This factor pertains to the ability of those currently providing medical support to expand their capability. This area applied only to RC

provider units and Active Component medical treatment facilities (MTFs). Written surveys were used with the military providers. This area was also part of the interviews with the RSC and STARC surgeons staff members.

2.2.5 Impact on the System. This study element considers the impact on the RC provider unit due to the provision of medical readiness support. Specifically, the conflict with training to the wartime mission essential tasks and the provision of medical support. An inquiry was made regarding the amount of full-time support effort required each month in scheduling medical support, obtaining medical supplies, and other associated administrative duties regarding the medical support mission. System impact information was requested by a written survey to the RC provider units and was requested during the interviews.

2.2.6 Lost Training Time. Lost training time pertains to the loss of training time in customer units associated with the requirement to obtain medical readiness support. Factors such as individual absences from scheduled or make up training, loss of instructor staff, and missed collective training opportunities were considered. Information relevant to lost training time was requested by a written survey to the RC provider units and requested during the interviews

2.2.7 Other Costs. The SRA team attempted to capture the types and a general magnitude of additional costs sustained by provider or customer units associated with medical readiness support. Information regarding other costs was solicited by a written survey to the RC provider units and was requested during the interviews.

An electronic spreadsheet was developed to capture and perform calculations on the data received from the RC provider units (ARNG and USAR). The spreadsheet is too large to be enclosed in this report in hardcopy format but is provided separately in electronic form.

SECTION 3. FINDINGS

As described in Section 2, this study focused on medical readiness support to the reserve components, potentially available through a number of sources. The purpose of the study was to determine the most efficient and cost effective means of accomplishing medical readiness requirements. Each of the subsections of Section 3 evaluates the providers' capability against one of six criteria. Cost and accessibility, two aspects with relatively greater weight to the final recommendations. are considered first.

3.1 Cost

In accordance with applicable regulations, the SRA team defined the medical readiness requirements under consideration, constructed a profile to determine the elements of each and then researched available data sources to determine costs in potential provider systems. Each requirement is considered in a section below.

3.1.1 Physical Examinations. The SRA team considered three types of physical examinations; the routine periodic examination, the Flying Duty Medical Examination (Flight Physical), and the initial examination required for entry into Special Forces, Special Forces marine diving, other marine diving. military freefall parachute (MFF), and Search, Evasion, Resistance and Escape (SERE) training programs. All members of the National Guard and US Army Ready Reserve are required to have a periodic examination at least once every five years. Examinations are required more frequently for aviation personnel (annual); Special Forces combat divers, MOS OOB divers, and military freefall parachutists (every 3 years); and members of the selected reserve who are over 40 years of age and are assigned to units scheduled for deployment within 75 days after mobilization (every 2 years). The tests and procedures included in physical examinations also vary according to gender and age.

Data from the Defense Manpower Data Center (DMDC) indicate that, as of March 1998, the overall percentage of personnel over 40 years of age is 17.8 percent in the USAR Ready Reserve and 23.8 percent in the Army National Guard. The percentage of female personnel is 21.3 percent in the USAR Ready Reserve and 9.5 percent in the Army National Guard. The examination requirements are outlined in Army Regulation 40-501(paragraph 8-19a(1), paragraph

8-19c(2), and paragraph 8-19c(4); National Guard Regulation 40-501(paragraph 2-9); Title X, US Code (Sections 1074b and 10206); and ATB 2, Army Flight Surgeons Administrative Guide.

3.1.1.1 Periodic Examinations. Potential provider costs for periodic examinations are discussed below.

- **Army Medical Treatment Facilities.** The cost of a routine periodic physical examination in an Army MTF is expressed in MEPRS data for Medical Examination Clinics. The FY 98 MEPRS (per inquiry in May 98) data indicate an average cost per visit to these clinics of $127.78. All periodic examinations require the completion of item 44 (Dental) on the Standard Form 88 (Report of Medical Examination). However, MEPRS data, as currently recorded and reported, are considered a less accurate accounting of the cost of particular dental procedures, such as the periodic oral examination. Therefore, on advice of the Office of the Army Surgeon General the DOD Reimbursable Rate Schedule, with weighted values applied, was used in lieu of MEPRS to determine the cost of the dental examination. The cost of a periodic dental examination (ADA Codes 00120 and 00274) in an Army dental clinic is $63.63. The total cost of the periodic physical examination, using this methodology, is $191.41.

- **Reserve Component System.** The study team could not identify a standard system of accounting similar to MEPRS, within the Reserve Components with data to use as the basis for estimating the cost of a periodic, or other, physical examination. Examination sites vary in terms of available manpower, equipment, laboratory capabilities and administrative support. For example, sites that must refer required tests to a contracted laboratory or radiology service would incur different expenses than those that perform the tests with organic laboratory capability. One source, responses to the study questionnaire from RC examining sites, provided no data from which a valid cost, or estimate, could be established. Responses ranged from $3.90 to $200.00, without considering manpower costs. A second option, given the similarity in manpower, equipment, supplies and administrative costs for a physical examination at a Reserve Component examining site and one at an Active Component MTF is the MTF average cost. In the absence of actual cost data, the MTF cost appears to be a reasonable estimate. Therefore, for the purposes of this study, the cost

of physical examinations within the Reserve Component System is assumed to be the same as in the Active Component.

In a noteworthy initiative to accomplish medical readiness, the National Guard is establishing TDA Medical Detachments in each state. According to the Office of the Surgeon, National Guard Bureau, fifty-four such detachments are programmed to be operational by December 1999. These organizations should allow for more standardized reporting and cost accounting in the future. The cost of meeting medical readiness requirements within this system of National Guard TDA Medical Detachments should be evaluated over time. The ARNG has identified over 4,000 personnel authorizations to staff the 54 detachments.

- **The Department of Veterans Affairs.** The Department of Veterans Affairs' (DVA) responded positively to the study inquiry. A number of VA medical centers have already established sharing agreements to provide physical examinations to reservists, and the Department is interested in expanding such services. VA currently has a system of over 500 medical centers and clinics throughout the 50 states, as well as in Puerto Rico, the Virgin Islands, Guam, and the District of Columbia. The DVA responded that it would be premature to provide reimbursement rates but, typical rates involve discounts from the CMAC rates for CPT codes which make up the various examinations and services. The DVA Headquarters has not issued a department-wide discount rate because agreements would be negotiated at the DVA's subordinate Service Networks. A 15 percent discount was selected for purposes of this study although informal discussions during the course of the study indicate that DVA providers have agreed to discounts up to 25 percent for various services. Examples of reimbursements that DVA would be willing to accept for various tests and procedures were provided by the VA Medical Center, Jackson, MS. The medical center has many years of experience in sharing agreements with Department of Defense and other Federal agencies and is considered an appropriate model for the purposes of the study. An important factor in determining costs – the length of time spent by the provider in conducting examinations – was addressed by the medical center. In their experience, many examinations require 30 minutes of provider time, which is the equivalent of CPT Code 99203. More or less time is required depending upon the complexity of the examinations for those under or over 40 years of age, male vs.

female, flight physicals, etc. Costs for examinations requiring 10, 15 and 30 minutes of provider time are shown in Appendix B.

- **Civilian Contractors.** Two potential civilian contractors responded to the study inquiry; ORKAND Corporation of Falls Church, VA and Continuum Healthcare, Inc. of Atlanta, GA. ORKAND Corporation is currently under contract with the Department of Defense Medical Examination Review Board (DODMERB) to coordinate physical examinations required for applications to Service Academies and scholarship ROTC programs. Continuum Healthcare, Inc. has an extensive network of clinics capable of providing physical examinations. The organization does not currently have a dental capability but is in the process of establishing a network. The prevailing dental fee (national median) for an oral examination by private practitioners was added to Continuum's price quotations in order to compare total cost against other providers. Reimbursement rates that these organizations would require for physical examinations are shown in Table 3-1.

  As indicated above, the national level civilian healthcare providers contacted during the study declined to participate, primarily because of propriety of provider networks and costing methodologies. Since the cost of contracted services have generally been established by discounting CHAMPUS Maximum Allowable Charges (CMAC), a profile of rates for physical examinations in thirteen states was extracted from the 1 February 1998 CMAC rates. The profile includes at least one state in each of the eleven TRICARE regions. The resulting costs, along with discounted rates, are shown in Appendix B. The intent of the cost profiles is to include in the study a best estimate of reimbursement rates that could be negotiated with other civilian contractors, and provide a basis for comparing those costs with other potential providers. A 10 percent discount rate was applied to CMAC rates for this purpose. In the absence of responses from major providers, such as Humana, Foundation Health, TRICARE, Aetna US Healthcare, etc., this methodology was considered to provide a conservative but reasonable estimate to use in cross comparisons of providers.

- **ORKAND Corporation.** Examination costs provided by ORKAND Corporation are shown in Table 3-1.

- **Continuum Healthcare, Inc.** Examination costs provided by Continuum Healthcare, Inc. are shown in Table 3-1.
- **Private Physicians.** A final option for routine physical examinations is that reservists obtain an examination from private physicians. Cost estimates were based on billings on file in the Finance and Accounting Office, US Army MEDCOM. These billings, for FY 97, represent physical examinations provided to reservists by private physicians at various locations. The average charges were $105.00 for an examinee under 40 years of age and $156.00 for over 40 years of age. No flying duty medical examinations or other types of physical examinations were included in the billings. The costs were considered as billed, but the tests and procedures included in examinations were not standard. Examinations varied by CPT code content and by location of the providers. Also, there was no indication of the length of time spent by providers in conducting the examinations. Charges for provider examination time billed to MEDCOM were of a range equivalent to 10 minutes (CPT Code 9921) to 30 minutes (CPT Code 99203). The absence of standard examination profiles and costing methodologies does not allow for a valid comparison to the cost in other systems. The cost of private physician contracting, if used extensively to accomplish standard AR 40-501 physical examinations or other readiness requirements, would likely be similar to civilian contracting in general and be based on CMAC rates with or without discounts. In smaller communities' physician are less likely to offer discounts.

3.1.1.2 Flying Duty Medical Examinations (Flight Physicals). As in the case of periodic physical examinations, the SRA team constructed a profile of tests and procedures required for Flying Duty Medical Examinations with CMAC rates applied. See Appendix B

The requirements for training and credentialing in Aviation Medicine limit the potential sources for flight physicals. Whenever possible, the examinations must be performed by a military Flight Surgeon. When a Flight Surgeon is not available, the examinations may be conducted by any military or Department of the Army, or contract civilian physician, but a Flight Surgeon or Aviation Physician Assistant must review and sign the Report of Examination prior to sending the results to the US Army Aeromedical Center (USAAMC), Fort Rucker, AL for central review. According to data provided by the Defense Manpower Data Center (DMDC), as

of March 1998, there were approximately 14,000 aviation personnel (Off, WO, Enl) in the Army National Guard and US Army Ready Reserve, of whom approximately 1,000 were female. DMDC data show only 76 Flight Surgeons in the Army Ready Reserve and 83 in the National Guard as potential providers/reviewers of these 14,000 annual examinations.

The USAMMC is not aware of any Flying Duty Medical Examinations, for US Army aviation personnel, being conducted by providers outside the Department of Defense. Nonetheless, the potential providers contacted during this study were asked to provide a cost of conducting the examinations in accordance with the examination profiles provided. Costs associated with recruiting, training and certification of examiners were not considered. The cost of the examinations by each provider are summarized Table 3-1.

- **Army Medical Treatment Facilities**. The cost of flying duty medical examinations in an Active MTF is expressed in MEPRS data for the Flight Medicine Clinic. The FY 98 MEPRS (per inquiry in May 98) data indicate that the average cost per visit to these clinics is $84.57. As in the case of the periodic examinations, a dental examination is required at a cost of $63.63. The total cost, then, of a flying duty medical examination is $148.20. The FY 98 DOD Reimbursable Rate Schedule shows the examination cost as $157.00. The lower cost for the more complex flight physical as compared to routine periodic examinations appears to reflect the primary care mission of the Flight Medicine Clinic, which also provides dependent care. These primary and dependent care visits are factored in with flight physicals to reduce the average cost per visit at the clinic. For consistency in this study, the actual cost of conducting the flight physical should be at least as much as a routine periodic examination, which is $191.41. The differences between the periodic and flight physical examination profiles (under 40 years of age) are provider time and an electrocardiogram. The $191.41 is considered more accurate, for comparison to other providers, than the $148.20 derived by adding MEPRS data for a Flight Medicine Clinic visit and the dental examination costs.

- **Reserve Component System.** As in the case of periodic medical examinations, the cost of the flying duty medical examinations, when conducted within the Reserve Component System can not be determined from available data. The Active Component MTF cost was used in the study as the most reasonable estimate.

- **The Department of Veterans Affairs.** In accordance with the guidelines received from the Department of Veterans Affairs, in response to the study inquiry, the DVA could conduct examinations for CMAC rates less a discount. The study team selected a fifteen- percent discount rate for the purposes of this study. The resulting costs appear in Table 3-1 and Appendix B.

- **ORKAND Corporation.** Examination costs provided by ORKAND Corporation are shown in Table 3-1.

- **Continuum Healthcare, Inc.** Examination costs provided by Continuum Healthcare, Inc are shown in Table 3-1.

- **Private Physicians.** The US Army Aeromedical Center Fort Rucker, AL is not aware of any examinations being conducted by private physicians for Army aviation personnel and does not consider the use of private providers to be a viable option. Nonetheless, potential providers were asked to give a cost for conducting the examinations, assuming the availability of qualified examiners. The costs of the examinations by each provider are summarized in Table 3-1, illustrated on page 3-8.

3.1.1.3 Miscellaneous Medical Examinations. Reserve Component members applying for training courses in Special Forces, Special Forces/Ranger Combat Diving, other marine diving (MOS 00B), Military Freefall Parachuting (MFF), and SERE (Survival, Evasion, Resistance and Escape) require an initial physical examination as outlined in paragraph 8-12f, Army Regulation 40-501. These initial examinations include more tests and procedures than the routine periodic examination. The Reserve Component strength in the CMF 18 Series (Special Forces) is approximately 2,400. (Data from Defense Manpower Data Center (DMDC)). The number of Reserve Component personnel holding Addition Skill Indicators (ASI) in Special Forces Underwater Operations (ASI W7), Special Forces Military Freefall Operations (ASI W8) total 197 as of March 1998. There are 36 Reserve Component personnel holding MOS 00B as of that date (Strength data from DMDC).

The SRA Study team attempted to determine the number of applications submitted, and therefore the number of initial examinations required. Inquiries were made to the National Guard

Bureau, AR PERSCOM, the Defense Manpower Data Center; and the Special Operations Center and School, Fort Bragg, NC. The Army Training Requirements and Resources System (ATRRS) was also queried but no information was found.

Table 3-1 Cost of Periodic and Flying Duty Examinations

Potential Providers	Periodic Physical Examination				Flying Duty Medical Examinations			
	Under 40*		Over 40**		Under 40**		Over 40**	
	Male	Female	Male	Female	Male	Female	Male	Female
AC MTFs (MEPRS Data)***	$191.41	$191.41	$191.41	$191.41	$191.41	$191.41	$191.41	$191.41
RC Units	$191.41	$191.41	$191.41	$191.41	$191.41	$191.41	$191.41	$191.41
DVA(Assumes CMAC less 15%)	$162.29	$184.49	$227.10	$249.30	$209.64	$231.84	$227.10	$249.30
ORKAND Corp.	$215.00	$230.00	$250.00	$265.00	$260.00	$275.00	$275.00	$290.00
Continuum	$182.62	$236.72	$253.62	$284.62	$244.62	$288.62	$263.62	$294.62
Civilian Contract (Assumes CMAC less 10%)	$171.84	$195.34	$240.46	$263.97	$221.97	$245.47	$240.46	$263.97

*CMAC rates for under 40 years of age based on 15 minutes with providers (CPT Code 99213). 82% of the Army Ready Reserve and 76% of the ARNG are under 40 years of age (Per Defense Manpower Data Cener).

**CMAC rates for over 40 years of age and all FDMEs based on 30 minutes with providers (CPT Code 99203).

*** Cost per visit as recorded in FY 98 MEPRS data. FDMEs are not distinguishable from other care given in Flight Medicine Clinics (Average Cost of $84.57). FDMEs are at least as expensive as other examinations ($191.41).

NOTES:

1. Costs in Active Component MTFs is taken from Army MEPRS data.
2. Costs in Reserve Component Units is considered the same as AC in the absence of comparable cost accounting.
3. Costs at DVA facilities is based on information provided by DVA Sharing Office and DVA Medical Center, Jackson, MS.
4. Contract (CMAC) costs are extracted from current CMAC rates listed at www.ha.osd.mil.
5. ORKAND Healthcare and Continuum Healthcare costs are as provided by those companies.

In order to establish a cost for these miscellaneous examinations from sources outside the Department of Defense, a profile of the examination required for each training program was taken from AR 40-501. CMAC rates were applied by CPT code for each test or procedure

required. The CMAC rates were displayed for the same thirteen states included in the costing methodology for periodic physical examinations. The CMAC rates are shown in Appendix B.

- **Active Army Medical Treatment Facilities.** The cost of the miscellaneous examinations in an Army MTF would appear to be the same as for other physical examinations done in Medical Examination Clinics because MEPRS accounting cannot distinguish among the types of examinations conducted. As in the case of periodic examinations, the average Medical Examination Clinic visit is $127.78, and the average cost of the dental portion, using FY 98 DOD Reimbursable Rates with weighted values applied for ADA Codes 00120 and 00274, is $63.63. The total cost of the initial examinations would be $191.41. Discussions with the Special Operations Center and School revealed that many of these examinations are actually conducted at active MTFs.

- **Reserve Component System.** The cost of the initial physical examinations, conducted within the Reserve Component System, cannot be determined from available data. The Active Component MTF cost, $191.41, was used in the study as the most reasonable estimate.

- **The Department of Veterans Affairs.** In accordance with the guidelines from the Department of Veterans Affairs, received in response to the study inquiry, examinations would be conducted for CMAC rates less a discount. A fifteen- percent discount rate was selected for the purposes of this study. The CMAC rates, including discounts, are shown at Appendix B and in Table 3-2.

- **ORKAND Corporation.** Cost for the examinations provided by ORKAND Corporation are shown in Table 3-2.

- **Continuum Healthcare, Inc.** Cost for the examinations provided by Continuum Healthcare, Inc, are shown in Table 3-2.

- **Other Civilian Contractors.** Cost for the examinations from civilian contractors based on a CMAC discount of 10 percent is shown in Table 3-2.

- **Private Physicians.** The billings from private providers on file in the US Army MEDCOM did not include any examples of these Initial Physical Examinations for schools applications. The cost of private physician contracting, if used to accomplish physical examinations, would likely be similar to civilian contracting in general and be based on CMAC with or without discounts.

Table 3-2 Cost of Miscellaneous Initial Physical Examinations – Male Only (Special Forces, Marine Diving MFF, SERE Training)

Potential Providers	Training Programs				
	Special Forces (SF)	SF/Ran Combat Diving	Other Marine Diving	MFF	SERE
1. Active Army MTFs	$191.41	$191.41	$191.41	$191.41	$191.41
2. RC Units (CMAC rates)	$191.41	$191.41	$191.41	$191.41	$191.41
3. DVA (Assuming 15% CMAC Discount)	$210.28	$216.33	$223.44	$216.33	$143.26
4. ORKAND Corp.	$285.00	$285.00	$300.00	$285.00	$155.00
5. Continuum Healthcare, Inc	$322.62	$322.62	$357.82	$322.62	$219.00
6. Civilian Contract (Assuming 10% CMAC Discount)	$222.64	$229.06	$236.58	$229.06	$151.68
Full CMAC Rates	$247.38	$254.51	$262.87	$254.51	$168.54

NOTE: Applicants for these programs are generally under 40 years of age in good health. CPT Code 99213 (15 minutes) was selected as average time required by an examiner.

3.1.2 Dental Examinations. All members of the National Guard and members of the US Army Selected Reserve assigned to units scheduled for deployment within 75 days of mobilization are required to undergo an annual dental examination in accordance with National Guard Regulation 40-501, Paragraph 16-2; and Title X, US Code, Section 1074b. The requirement for the annual dental examination is fulfilled during those years when the 5-year periodic physical examination is accomplished, as that examination includes the dental examination. Approximately 400,000 members of the National Guard and USAR require annual dental examinations.

3.1.2.1 Active Army Dental Treatment Facility. The cost of an annual dental examination was taken from the DOD-HA, FY98 Schedule of Reimbursable Rates. MEPRS cannot isolate the cost of an annual dental examination. The annual examination, as defined in this study, consists of an oral evaluation (ADA Code 00120) and four bitewing x-rays (ADA Code 00274).

When needed, a panographic film, ADA Code 00330, is included. The DOD FY98 Interagency Reimbursable Rate for a dental procedure is $101.00. The DOD weighted values per ADA procedure code are: 00120 = .261; 00274 = .365; and 00330 = .626. The costs determined by this method are $63.63 without a panographic film and $127.26 with a panographic film. See Table 3-3.

3.1.2.2 The Reserve Component System. There is no standard system of accounting, within the Reserve Components, which would provide the cost of an annual dental examination performed by a RC dentist at a RC examining site. Sixteen responses to the study survey, from RC units, indicated no cost data for dental examinations. Other responses ranged from $1.00 to $70.00 without including manpower costs. The manpower, equipment, supply and administrative costs would be approximately the same as for the Active Component, or $63.63. When estimating the cost of an annual dental exam performed at a RC examining site, use of the Active Component dental facility cost is considered reasonable for purposes of this study. See Table 3-3.

3.1.2.3 The Department of Veterans Affairs. The cost of an annual dental examination, as defined for this study and provided at the VA Medical Center, Jackson, MS is $38.00. The cost would be $59.00 with a panographic film included. The Medical Center cost was used for purposes of this study in the absence of CMAC data and given the non-applicable nature of private practitioner fee schedules to the DVA. See Table 3-3.

3.1.2.4 ORKAND Corporation. ORKAND Corporation will provide the annual dental examination for $75.00. or $125.00 with a panographic film included. See Table 3-3.

3.1.2.5 Continuum Healthcare, Inc. As previously discussed, Continuum Healthcare Corporation is in the process of establishing a dental provider network.

3.1.2.6 Other Civilian Contractors. Programming data provided by the ARNG and USAR show an estimated cost of $46.00 and $52.32 respectively for an annual dental exam from civilian contractors. The ARNG cost was determined similarly to this study methodology, using a different survey of prevailing fees. The USAR data are based on the projected cost of premiums for enrollment in The Selected Reserve Dental Insurance Program (TSRDIP). Benefits of the program satisfy the requirement for the oral examination. The program includes treatment

as well as periodic examinations. The cost for examinations only could not be obtained. An example of fees for an oral examination under TSRDIP is shown in Table 3-3.

3.1.2.7 Private Providers. The prevailing fees, nationally, for the required dental examination and panographic film when received from a private provider were taken from the 1997 Fee Survey published by Dental Economics Magazine, May 1997 Issue. The 1998 survey is not scheduled for publication until the December 1998 issue. The May 1997 survey shows fees charged in 1996 and represents a 3.7 percent increase over 1995 fees. The rates shown in Table 3-3 represent the 1996 rates plus an inflation factor of 3.7 percent for 1997 and again for 1998. The national median prevailing fees by private practitioners in 1998 was thus determined to be $51.62. With a panographic film, the prevailing median fee would be $109.69.

Fee schedules for dental examinations conducted by United Concordia, Delta Dental, Humana (TSRDIP) and Mutual of Omaha dental plans were provided by the company, extracted from the organization's website, or obtained from a local dentist participating in the program. United Concordia, Delta Dental and Mutual of Omaha fee schedules are national. Humana did not respond to the study inquiry and national fees were not obtained. Humana (TSRDIP) fees are for the state of Texas only. The Texas fee schedule was obtained from a local dentist participating in TSRDIP. Delta Dental likewise was reluctant to supply provider networks or estimated costs in the absence of a contract proposal. As shown in Table 3-3 the fees for an annual dental examination from these potential providers ranges from $35.00 to $48.00 for the required examination and $75.00 to $98.00 with a panographic film. For purposes of comparison with other potential providers, the average cost of an examination from these agencies is $42.40 without a panographic film and $88.48 with a panographic film. These costs represent negotiated fees at provider sites. They do not consider premiums, co-pays or other costs associated with negotiated contracts. Also, the fees are for services to a variety of beneficiary populations; selected reservists, family members and retirees. The intent of including this information in the findings of the study is to provide some estimate of what it would cost to acquire only the needed examinations without treatment. Table 3-3. is illustrated on page 3-13.

3.1.3 Eye Examinations. Members of the Army National Guard and US Army Reserve who need inserts for protective masks or spectacles for deployment are responsible for maintaining a current refraction. The results should be recorded at the individual's unit. For readiness purposes, units have access to the Spectacle Request Transmission System, (SRTS) which allow

the unit to maintain a file of inserts/spectacles required and prescription information on deploying individuals. SRTS will create a database of electronic DD Forms 771 that can be sent electronically to a supporting laboratory. For OCONUS deployments, the data file can be sent to the laboratory with a deployment date. The laboratory will fabricate the inserts and return them to the unit using overnight carriers or express mail.

Table 3-3 Cost of Dental Examinations

POTENTIAL PROVIDERS	FEES BY ADA CODES*				
	00120	00274	00330	Total Without Panogram	Total With Panogram
Army Dental Facility based on FY 98 DOD Reimbursable Rates**	$26.26	$37.37	$63.63	$63.63	$127.26
Reserve Component Units based on AC Dental Facility cost***	$26.26	$37.37	$63.63	$63.63	$127.26
Department of Veterans Affairs	$18.00	$20.00	$21.00	$38.00	$59.00
	Fees provided by DVA Medical Center, Jackson, MS****				
Humana - Selected Reserve Dental Insurance Program - Texas Fee Schedule	$15.00	$20.00	$40.00	$35.00	$75.00
	Humana Military Healthcare, Inc did not respond. Fees were acquired by SRA from a participating provider.				
Delta Dental Insurance Company National Average Fee Schedule	$18.50	$25.10	$46.30	$43.60	$89.90
	(Fees for current TRICARE Retiree Program)				
United Concordia Companies National Average Fee Schedule	$20.00	$28.00	$50.00	$48.00	$98.00
Mutual of Omaha Contracted Dental Program Fee Schedule	$18.00	$25.00	$48.00	$43.00	$91.00
ORKAND Corporation	$35.00	$40.00	$50.00	$75.00	$125.00
Dental Economics Magazine Annual Fee Survey - Prevailing Rates 5/1/1997(Adjusted for Inflation)	$21.50	$30.11	$58.07	$51.62	$109.69

*ADA Codes - 00120 Periodic Oral Examination, 00274 - Bitewing x-rays (4), and 00330 - Panoramic Film.

** MEPRS data (cost per procedure) is considered inadequate for fixing the cost of a periodic oral examination. Cost was determined by applying DOD weighted procedures to the DOD Dental Reimbursable Rates for FY98.

*** Insufficient data available for RC. Skills, supplies and equipment are assumed to be comparable to costs in AC dental facilities.

****The DVA Medical Center, Jackson, MS, has a progressive program of sharing agreements with Department of Defense and other Federal Agencies. The Medical Center is considered a valuable model for the purpose of this study.

For deploying personnel with a short suspense, this process should take 2-3 days from when the order is placed until received. Depending on command policy and availability of funds. the inserts could be ordered at any time. The accessibility to and cost of a refraction is the focus of this study.

3.1.3.1 Active Component Medical Treatment Facility. The cost of a refraction in an active Army treatment facility is one portion of MEPRS cost for an Optometry clinic visit. FY 1998 MEPRS data show the cost of an optometry clinic visit to be $67.28. While efforts are underway to establish one, there is currently no standard schedule of weighted values, which would isolate the cost of a refraction. The Chief, Optometry at Brooke Army Medical Center estimates that a refraction, based on the time spent relative to other procedures, would account for approximately one-third of the average cost per clinic visit. One third of the MEPRS cost per clinic visit in an active Army MTF is $67.28 X 1/3, or $22.43. See Table 3-4.

3.1.3.2 The Reserve Component System. There is no standard system of accounting, within the Reserve Components. which would provide the cost of an optometry visit. As in the case of the other medical readiness requirements, the MEPRS cost data for Active Component MTFs and the cost of conducting the examination at a Reserve Component site should be approximately the same.

3.1.3.3 Department of Veterans Affairs. The average CMAC rate determined in the study. discounted by 15 percent as was done for other requirements in costing DVA services, would set the average cost at $39.57. See Table 3-4.

3.1.3.4 ORKAND Corporation. ORKAND Corporation's charge for an eye examination is $40.00. See Table 3-4.

3.1.3.5 Continuum Healthcare, Inc. Continuum Healthcare. Inc.'s charge for an eye examination is $40.00. See Table 3-4.

3.1.3.6 Civilian Contractors. (CMAC rates). The average cost for a refraction (CPT Code 92002) in the thirteen states for which CMAC data were extracted is $46.55. At the same discount rate of 10 percent applied to CMAC for other readiness requirements the refraction cost would be $41.90. The Optometry Consultant. Office of the Army Surgeon General

recommended, for medical/legal reasons, the use of CPT Code 92002 instead of the less costly CPT Code 92015. While simple refraction may be done for soldiers in basic training or for readiness/deployment purposes, a private sector provider would not likely provide an examination, which includes simple refraction only, and later be held responsible for not noting and treating other abnormalities. See Table 3-4.

Table 3-4 Cost of Eye Examinations

Provider System	Cost
Active Component Medical Treatment Facility	$22.43
Reserve Component System	$22.43
Civilian Contractors (CMAC less 10% discount)	$41.90
Department of Veterans Affairs (CMAC less 15%)	$39.57
ORKAND Corporation	$40.00
Continuum Healthcare, Inc	$40.00

3.1.4 Immunizations. Immunizations required for medical readiness vary according to unit missions, areas of expected deployment, host country requirement, or as directed by the Army Surgeon General.

Table 3-5 Cost of Immunizations

Immunizations	Army MTF*	RC Unit*	DVA	ORKAND Corporation	Continuum Healthcare	
					With Exam	Without Exam
Adenovirus types 4 and 7	$19.00	$19.00	$10.75	Not available	Not available	
Cholera	$19.00	$19.00	$16.38	$38.00	Not available	
Hepatitis A	$19.00	$19.00	$24.55	$49.00	$100.00 $100.00	$110.00 $110.00
Hepatitis B	$19.00	$19.00	$43.84	$24.33		
Influenza	$19.00	$19.00	$9.77	$28.00	$30.00	$40.00
JE Vaccine	$19.99	$19.00	$62.62	Not available	$95.00	$105.00
Measles	$19.99	$19.00	$20.42	-	-	-
Measles, Mumps, and Rubella	$19.99	$19.00	-	$38.00	$60.00	$70.00
Meningococcal	$19.00	$19.00	$40.83	$108.00	$99.00	$109.00
Oral Polio Vaccine	$19.00	$19.00	$17.83	$38.00	$50.00	$60.00
Plague	$19.00	$19.00	$27.25	$38.00	Not available	
Rabies	$19.00	$19.00	$110.23	$223.00	$185.00	$195.00
Tetanus-diphtheria	$19.00	$19.00	$19.50	$28.00	$25.00	$30.00
Typhoid	$19.00	$19.00	$9.04	$58.00	$40.00	$50.00
Varicella	$19.00	$19.00	$46.69	$34.00	Not available	
Yellow Fever	$19.00	$19.00	$174.90	$98.00	$95.00	$105.00

*Costs are from FY 98 DOD Reimbursable Rate schedule for Immunization Clinic Visit. MEPRS does not provide cost per immunization. The $19.00 average cost may represent multiple immunizations. Cost of vaccines, needles, syringes, manpower, etc., should be approximately the same in a Reserve Component unit.

**The DVA Medical Center, Jackson, MS, provided DVA costs. Cost will vary by DVA facility. CMAC rates do not include data on immunizations.

The cost of immunizations within each of the provider systems was determined by using the FY 98 DOD Reimbursable Rates for the Active and Reserve Component units and by responses from potential non-DOD providers. The reimbursable rate was considered to be the

most comparable data available among Components. The Reserve Components do not maintain cost data comparable to MEPRS. Furthermore, the MEPRS data available is presented as total expenditures assigned to Immunization Clinics without providing the number of visits, cost per visit, or cost per immunization. There are no weighted values assigned to individual immunizations. The DOD Reimbursable Rates are also based on Immunization Clinic Visits and do not account for the number of immunizations administered in a visit. A comparison of immunization costs is shown in Table 3-5.

3.1.5 HIV Testing All members of the Army National Guard and the United States Army Ready Reserve require periodic testing for Human Immunodeficiency Virus (HIV). Regulations governing the frequency of HIV testing are Army Regulation 600-110, Army Regulation 40-501, and National Guard Regulation 40-501. Army Regulation 600-110 states that all members of the Army Reserve, not on active duty, will receive the HIV screening every five years. Army Regulation 40-501, paragraph 8-19c(4), requires that all members of the US Army Ready Reserve undergo a physical examination that includes testing for HIV at least once every five years. National Guard Regulation 40-501, paragraph 2-9, likewise requires a complete periodic physical examination at least once every five years, to be conducted in accordance with Army Regulation 40-501, which includes HIV Testing.

While the five-year periodic physical examination is most soldiers' primary means of meeting the HIV Medical Readiness Requirement, there are cases that require more frequent testing. For example, members of the Selected Reserve who are 40 years of age or older and are assigned to units scheduled for deployment in 75 days or less must have a complete physical examination no less frequently than every two years (Title X, US Code). Reserve Component personnel ordered to Active Duty for a period of more than 30 days must have been tested for HIV antibodies with negative results within the 6 months prior to the report date and prior to issuance of orders (Paragraph 5-2, Army Regulation 600-110). Annual Flying Duty Medical Examinations and triennial periodic examinations for Special Forces/Ranger marine divers, other marine divers, and Military Freefall Parachutists (MFF) required by Army Regulation 40-501 include HIV testing.

3.1.5.1 Active Component Medical Treatment Facility. HIV testing in an active MTF, when done for force screening or any other non-clinical purpose, is done by contract at a current cost per test of $3.27. The test may be accomplished in compliance with a valid request from a

soldier's unit. No referring provider is necessary. The cost to the laboratory is minimal and no MEPRS expense is charged to a referring clinic. (Information provided by the Army Laboratory Program Manager, US Army MEDCOM). An exact cost, to include labor, supplies, etc., will vary among MTFs. However, the minimal laboratory costs involved plus the $3.27 for the test is much less than in non-DOD systems considered in this study. For purposes of this study, the cost of the HIV test in an MTF is considered to be $3.27.

3.1.5.2 The Reserve Component System. The Reserve Components are included in Department of Defense contracts for HIV testing. The manpower, supplies and equipment necessary to collect and process blood samples to the contractor for testing are approximately the same as for the Active Component medical treatment facilities. For the purposes of this study the cost of an HIV test is the same ($3.27). Even if other administrative expenses were determined and added, the cost of an HIV test in the Reserve Component system would be less than in other systems included in this study.

3.1.5.3 The Department of Veterans Affairs. In accordance with guidelines received from the Department of Veterans Affairs, in responding to the study inquiry, HIV testing would be conducted for CMAC rates less a discount. The average CMAC rate in the thirteen states included in the study is $34.90 which, with a fifteen percent discount as applied in the other medical readiness requirements, establishes an average cost of $29.66. See Table 3-6.

3.1.5.4 ORKAND Corporation. When collected at a laboratory site the cost of HIV is $18.00. When collected at a provider site the cost is $25.00. See Table 3.6

3.1.5.5 Continuum Healthcare. The cost for a separate HIV test provided by Continuum Healthcare, Inc, is $40.00. See Table 3.6

3.1.5.6 Civilian Contracting - CHAMPUS Maximum Allowable Charges. The average cost for HIV testing in the thirteen states for which CMAC data were extracted is $34.90. A 10 percent discount was applied to the CMAC rates for the purposes of the study. The average cost expected from this methodology is $31.41. See Table 3.6

3.1.5.7 Private Physicians/Clinics. The cost billed to the US Army MEDCOM by private physicians/clinics for HIV testing in conjunction with physical examinations ranged from $7.00

at Roanoke-Salem Clinic in Roanoke, VA to $86.80 from a private practitioner in Tulsa, OK. The average cost of the HIV test billings was $40.70. (See Table 3.6 illustration on the next page).

Table 3.6 Cost of HIV Testing

Provider System	Cost
Active Component Medical Treatment Facility (Brooke Army Medical Center Laboratory)	$3.27
Reserve Component System	$3.27
Civilian Contractors (CMAC less 10% discount)	$31.41
Department of Veterans Affairs (CMAC less 15% discount)	$29.67*
ORKAND Corporation	$18.00 to $25.00**
Continuum Healthcare, Inc	$40.00
Private Physicians/Clinics (average of billings paid by US Army Medical Command Finance and Accounting).	$40.70

*Current CMAC rates less 15 percent. Cost is negotiable depending upon volume to be tested.
** $18.00 if collected at a laboratory site. $25.00 if collected at a provider site.

3.2 Accessibility

The accessibility of the medical readiness support is the most important concern from the perspective of the Reserve Component customer unit or individual A distance of 75 miles was used as the base distance in the analysis since a reservist leaving home at 6:00 A.M. should be able to arrive at a medical readiness site by 8:00 A.M. to receive medical readiness support. A desirable provider will have a high percentage of RC customer units within its' 75 mile umbrellas. To evaluate accessibility, the SRA team compared the locations of ARNG and USAR units, defined by zip codes, with the locations of the providers, also by zip codes. Zip codes of the customer units were obtained from NGB and USARC. The RC provider identified zip codes of medical readiness support locations on the survey. Non-RC providers provided zip code databases of their networks.

The team plotted three situations: ARNG units only, USAR units only, and a composite reflecting all ARNG and USAR units. Using mapping software, the SRA Team compared provider sites with their surrounding area to 75 miles (indicated by yellow circles). The program also calculated percentage of customer units within 75 miles of a provider source. The percentages of accessibility to specific providers by ARNG, USAR and a composite of both are reflected in Table 3-7 . The actual "provider/customer plots" appear in Appendix A.

Table 3-7 Percent Accessibility Matrix

	PROVIDERS	ARNG UNITS	USAR UNITS	ALL RC UNITS
1	ORKAND CORPORATION	86.7	89.6	87.0
2	CONTINUUM HEALTHCARE	97.0	98.6	97.3
3	DEPARTMENT OF VETERANS AFFAIRS	96.3	98.3	96.3
4	ARMY MEDICAL TREATMENT FACILITIES	20.5	25.0	21.5
5	MILITARY ENTRANCE PROCESSING STATIONS	69.2	74.5	70.4
6	ALL RC PROVIDERS	77.1	81.3	80.3
7	ALL ARNG PROVIDERS	64.3	60.9	68.8
8	ALL TDA (COMPO 2 & 3)	66.1	67.0	70.4
9	USAR TDA ONLY	19.4	28.0	16.7
10	ALL USAR	36.9	61.4	41.4

There were two providers that ranked above 95 percent in their site accessibility to RC customer units; Continuum Health Care and the Department of Veterans Affairs. ORKAND Corporation ranks third with a rating of 87 percent; these percentages should be qualified as follows:

1. Because the ARNG or the USAR units did not provide complete provider site zip code information, the accessibility percent for the individual RC provider plots will be low.

2. With ARNG providers', 75 mile radius may cover units in adjacent states. In reality, they will not provide medical readiness to those units. The result is artificially high values for the ARNG provider plots.

3. These plots reflect accessibility of selected providers, not their willingness to provide the service.

On the RC provider survey, forty-five RC providers indicated supporting RC units that traveled 200 miles or greater one way to receive medical readiness support. Based on the survey responses, the primary problem is accessibility to the support site rather than the ability to get the appointment. An improvement in the "no-show" rate in the USAR (as high as 40-50 percent in some areas was reported) would make a considerable improvement in the provider output.

Therefore, based strictly on accessibility, the providers of choice are:

- **Continuum Healthcare**
- **Department of Veterans Affairs**
- **ORKAND Corporation**

3.3 Expansion Capability

The expansion of systems currently providing medical readiness support is a quick and relatively inexpensive method to increase medical readiness support. The SRA team used surveys and interviews to determine the expansion capability of systems currently providing medical readiness requirements support. The conditions used in this analysis were that the supporting system be capable of expanding medical support without a corresponding increase in authorized personnel or facilities. Since the ability to expand assumes that there is support being provided now, this factor only applies to the Reserve Component providers and Active Component MTFs.

3.3.1 Active Component MTFs. The SRA team posed four questions to the six Regional Medical Commands. The RMC survey, at Appendix C, requested information on the amount of support presently provided to the ARNG and the USAR by the Active Army MTFs in their region. Two of six RMCs responded to the survey. Both RMCs indicated a significant number of physicals provided to RC soldiers in their MTFs. The majority of these physical examinations were completed on the weekends by Reserve Component units using the MTF facilities. This information was captured from respondent RC providers. The requested information is apparently not captured by the Active Component MTFs.

3.3.2 Reserve Component Providers Survey results regarding additional support capability in terms of the number of additional unit training assemblies (UTA) per month were: 148 additional UTA/month for ARNG providers and 190 additional UTA/month for USAR.

Survey responses indicated that the factors below would limit the ability to expand medical readiness support:

Table 3-8 Expansion Limiting Factors

ARNG Total	USAR Total
29 physician shortage	35 physician shortage
24 facilities	13 facilities
23 supporting staff	14 supporting staff
17 equipment	17 equipment
	4 lab support

As seen in Table 3-8, a total of 64 RC provider agencies indicated the availability of direct care providers would inhibit expansion. Certainly this shortage of providers, at least in some locations, affects existing capability.

In conclusion, the overall expansion ability is negligible as a system improvement. The shortage of providers, at least in some locations, affects existing capability.

3.4 Impact On Provider Units

The study team examined the impact of providing medical readiness requirements on the systems providing that care. The team requested information from Active Component medical treatment facilities and Reserve Component medical units.

3.4.1 Active Component MTFs. Definitive information was not available. It is the impression of the study team that most of the support being provided in the Active Component MTF is completed on the weekends using RC staff resources. Some support is provided during the week, primarily during annual training. The support provided in Active Component MTFs, by MTF staff, is a small percentage of the overall requirement. Attempts to capture the specific data were unsuccessful.

3.4.2 Reserve Component Medical Units. The team examined the effect of providing medical readiness support on the RC unit providers. It is important to remember the basic differences in the nature of the provider units in the ARNG and the USAR when assessing the relative impacts. For example, since the sole mission of ARNG Medical Detachments is to provide medical

readiness support to their units, there is no conflict with any other mission. The USAR situation is quite different. Many survey comments indicated a concern for the conflict between providing medical readiness support on drill weekends and using that time for wartime mission task training. This concern applies to all USAR provider units, MTOE and TDA. Both ARNG and USAR respondents indicated a concern for the morale of the physician providers. Specifically, the small numbers of available providers require them to provide medical readiness support on regular basis, thus excluding them from unit training. The physicians drill at remote medical support locations and frequently do not see other unit members. They become very dissatisfied with the same routine support duties month after month. The morale concern is probably a significant retention factor with this group. RSC and STARC staff expressed concerns with providing medical readiness support instead of training for wartime missions (except for the State Health and Dental Detachments in the ARNG).

Reserve Component medical units, except ARNG TDA units, have wartime missions and therefore wartime training requirements. While there is no impact of providing medical readiness support by the ARNG TDA units, there is a negative impact on wartime training for all other Reserve Component provider medical units. Also, the provision of medical readiness support is detrimental to physician retention in the RC.

3.5 Lost Training Time

The SRA team examined the impact on supported RC units of lost training time, in terms of both collective and individual training. The team examined the time required for the completion of medical readiness procedures and how the RC unit was affected by the extensive travel time to and from the supporting activity.

In 90 percent of the cases when an individual is required to receive medical readiness support, it is provided during the weekend drill at a RC provider site. The amount of lost training time is directly proportional to the number of soldiers requiring support and the distance to the medical readiness provider. The distance is the only variable that can be improved. Forty-five ARNG and USAR unit respondents reported they have provided support to members that travel at least 200 miles or more one way. This effort to receive medical readiness support requires at least one and sometimes two days of weekend training time. If planned reductions are approved in the USAR, nine units currently providing medical support will be eliminated

(based on information obtained from USARC and MEDCOM). This will only cause units to travel greater distance to receive necessary medical support.

Medical Readiness Support that is provided on the drill weekend is a distracter with respect to training time; it is likely to get worse.

3.6 Other Costs

The SRA team identified additional funding costs associated with completing medical readiness requirements. The study attempted to examine man-day costs associated with active duty for training (ADT) and additional training assemblies (ATA), cost of medical supplies, and cost of fuel to transport soldiers to the supporting medical activity. The team looked at how the use of fuel to transport personnel to supporting medical activities affected the RC unit's ability to accomplish unit wartime mission training. Many units identified additional costs associated with the effort to obtain medical readiness support, such as:

- Travel for supported and supporting RC personnel: fuel, vehicle maintenance, per diem, housing.
- Full time administrative workload needed to support the medical readiness effort.

There is not a defined system within the Reserve Components that accurately captures the spending for medical readiness support. Based on the extensive distances traveled by some units, there are significant costs sustained for travel and other related expenses. Many units reported they take the costs "out of hide" but are having problems meeting the requirements.

There are other significant costs involved. The finite amount is unknown.

3.7 Additional Issues Surfaced During the Study

Four issues emerged during the course of the study that demand consideration. The issues were not part of the original study plan; however, due to their significance, they were integrated into the assessment. Each is considered below.

3.7.1 ARNG and USAR Medical Programs The similarities and differences in the missions, the command and control, and purpose of the medical structure which are currently part of the ARNG and the USAR must be understood if appropriate conclusions and recommendations are to be made.

Several years ago, the bulk of the ARNG medical structure, which was not organic to their predominant divisional forces, was transferred to the USAR largely in exchange for the USAR aviation assets. Shortly thereafter, and since the ARNG had very little medical capability remaining for self-support, the concept of the State Health and Dental Clinics was advanced. TDAs were developed with staff and equipment, later to become separate medical detachments of the State Area Command (STARC) of each state. Approximately half of these detachments were functional by December 1997 and the remainder is to be operational by December 1999. The primary mission of these detachments is the provision of medical readiness support to the members of the ARNG. However, these units also have a state and community role, which is not present in the USAR. The STARC have directed these detachments to provide complete medical Soldier Readiness Processing to ARNG soldiers activated for duty at locations around the world prior to ever leaving their home station. In addition some 18 states are currently engaged in Medical Innovation Readiness Training. These are non-military state level programs that provide special medical support.

The medical structure in the USAR consists of MTOE and TDA medical units. Both types of medical units have wartime missions. In most cases the MTOE medical units are designed to deploy and provide medical support in a theater of operations, and the TDA units are designed to augment fixed MEDCOM facilities. The USAR has the large majority of medical resources in the Reserve Component with wartime missions. MTOE units are authorized equipment designed to support their wartime mission. This equipment is not the type that is normally needed to provide medical readiness support. TDA units are not authorized equipment since they augment MEDCOM MTF missions. Many USAR medical units are providing medical readiness support. Losses in medical structure in the USAR via downsizing are seriously eroding capability.

The reduction in the medical structure of the USAR has caused customer units to travel long distances for support during drill weekends. The RSC is looking to enter into local

agreements with the DVA or other providers for medical readiness support. The additional planned reductions will render this RSC unable to provide their units medical readiness support.

3.7.2 Medical Readiness Support: Weekend or Weekday Conversations with potential non-Reserve Component providers concerned the provision of medical readiness support during the week. Several providers indicated the likelihood of a substantially increased cost, due to staffing, if support was required on the weekend. SRA Team discussions regarding weekday support, as opposed to the conventional drill weekend support, generated the following observations:

- Any workload considered would be distributed over 20 available weekdays per month compared to 8 days on the weekend. This increases the available support days by a factor of 2.5.
- Those Reserve Component units currently providing medical readiness support could train to wartime missions or provide supplemental weekend support to units, as needed. *This factor is not applicable to the ARNG Medical Detachments that operate the State Health and Dental Clinics, since they do not have a federal WARTRACE aligned mission.*
- There would be no distracter from weekend training due to medical readiness requirements.
- There are two issues to be resolved if this method is used.

  Can the Reservist be available during the working week? There is more annual training days available per year than are commonly used or funded. In fact, according to one RSC Commander, units are currently being resourced for only 12 days of AT, as a cost saving initiative. By authorizing an individual fragmentary annual training for the specific purpose of receiving medical readiness support, employer conflict might be avoided. In addition, with much greater flexibility being afforded via the use of weekdays, "crisis periods" for employers could most likely be avoided. **The very restricted and special use of fragmentary AT, to allow the provision of weekday medical readiness support, may afford a real solution to many concerns.**

  Funding must also be provided to support this effort. Many of the weekday providers (non-RC) have high accessibility ratings reflecting proximity to the consumer units. The additional fragmentary annual training must be funded but may be partially

compensated by savings from a considerable reduction in transportation and other non-captured costs associated with the current program.

The question of weekday provision of medical readiness support was posed to many RC personnel in an attempt to identify unforeseen problems with this potential course of action. The large majority indicated their wholehearted support for this idea. Most said it was a good solution to a complicated problem. The SRA Team thinks this idea deserves very serious consideration!

3.7.3 High "No-show" Rates. A disturbing fact reported by both the ARNG and USAR providers was the high no-show rate. The no-show rate refers to those RC members scheduled for medical readiness support, who fail to report at the scheduled time the following month. In the USAR the rate reported was as high as 40 to 50 percent, and the ARNG 15-20 percent. Even though this is not a factor that was specifically addressed in any survey question, it indicates a significant waste of available medical readiness services. Perhaps the need for more command emphasis in the medical readiness program is indicated. The high no-show rate is also very frustrating to the provider staff (voiced by many individuals).

3.7.4 Lack of Consistency in Physical Examination Procedures. The team found a wide variety of methods and procedures used in the provision of medical readiness requirements, especially the periodic Physical Examination. The procedures found in AR 40-501 was used by the SRA team as the standard basis for comparison. In the interview with the DODMERB staff, the lack of consistency on the physical examination was a concern, not only among the components of a given service, but between the services themselves. The DODMERB staff thought this was one of the most serious problems with the Physical Examinations. This difference between the services and components should be resolved. The SRA team recommends a DOD level panel be formed to consider the matter of consistency in the Physical Examination for all services.

The SRA study team suggests the system in use by DODMERB be "benchmarked" as a starting point. The DODMERB program has several desirable characteristics. First, it provides detailed instructions generated by DODMERB for the direct care provider, via the ORKAND Corporation. Second, ORKAND provides an administrative Quality Assurance program that

may serve as an example. Finally, this program works nationwide and has addressed issues involved with nationwide continuity.

The Army RC system has 54 state or territorial headquarters in the ARNG and 10 Regional Support Commands in the USAR, all with multiple units. With so many provider groups, there are inconsistencies in the medical support provided. Any communication with this number of agencies would be difficult. The preferred situation is to have a single provider source for all medical readiness to all Reserve Component elements. A single source of direction, guidance, and resource support would greatly enhance continuity.

3.7.5 Limitations/Problems Associated with Survey. The attempt to capture costs of completing medical readiness requirements by Reserve Component providers, by means of a written survey, had limited success. Questions to determine the frequency of the provision of support (UTA/month), the average number of officer and enlisted members on a provider team, the number of sites operated per month, and operating cost of providing the support generated a wide variety of answers, many of which were suspect and unusable. It is clear to the SRA Team that a better system is needed in the ARNG and the USAR to both fund and account for costs associated with medical readiness requirements.

In the USAR the majorities of RSC level providers or below do not have a standard system to budget or account for medical readiness costs. The full implementation of the STARC Medical Detachments in the ARNG may improve the cost and accounting procedures in the ARNG.

In many areas of the study where numerical values were requested, the agencies simply did not provide them. In addition, some numerical data appeared to be outside a reasonable range. The study team suspects that some of the values requested are not being captured.

There were frequent subjective remarks provided with or instead of the data requested. These subjective comments appeared consistent with other reported information. The comments were compiled and displayed in tables in this report. In most cases, valid conclusions could be drawn from this collection of subjective remarks and related responses provided in the interviews.

SECTION 4. CONCLUSION

There are multiple concerns with the present methods by which reserve components units receive their medical readiness support.

4.1 The Reserve Component Provider Systems

The ARNG should be commended for taking the initiative in the areas of medical readiness support several years ago. The medical detachments operating the State Health and Dental Clinics, by almost all reports during interviews and surveys, are satisfactorily providing medical readiness support to the ARNG. However, their cost effectiveness may deserve another look. The total expense of establishing, staffing, equipping and maintaining facilities nationwide, in sufficient numbers to provide comparable accessibility to other established networks was not determined in this study but is formidable. With a multi-million-dollar annual price tag for the 4600 personnel in nationwide STARC medical detachments, it appears that other means of support may be less expensive. Yet to be determined is the value to be attached to the state and community role of the STARC Medical Detachment. Are the benefits realized to the state and community sufficient to offset the expensive undertaking of establishing a nationwide network of supporting units?

The USAR perspective, based on the survey and interview results, is that the medical readiness support system is already stressed and with additional reductions, soon will be almost nonexistent. This burden should be removed from the USAR provider units. Downsizing has forced the consideration of alternative providers. The medical support to the IMA and IRR is having similar problems according to an officer in the Health Services Division, Army Reserve Personnel Command.

4.2 A Philosophical Perspective

The purpose of Reserve Components is to accomplish their missions (state and/or federal) when called upon by proper authority. With this in mind, the limited training time should be used as much as possible in training to those missions. The Reserve Component should not be in the business of providing their own medical readiness support, unless there is a specific and direct training benefit to the provider unit. The basic idea of creating a nationwide medical

network within the RC to provide support to Reserve Component soldiers on weekends seems to be marching in the wrong direction. The ability to receive medical support should not be linked to the constantly changing number, strength, and physical locations of RC medical units. A preferred medical readiness support system must be stable. Other systems with an existing nationwide network of providers and facilities can provide the necessary services at a competitive cost.

4.3 System Conclusions

Funding support for this program must be planned and budgeted from a central source at DOD (HA) for all services or at a minimum at the Service level for all the Reserve Components of that Service. The medical element of each Service should be charged with responsibility for the provision of the necessary support, directly or indirectly (contracting), and administration and distribution of the program projected funds. Control of expenditures and the capture of medical readiness costs for historical purposes must be implemented by the Service program administrator.

A DOD (HA) sponsored panel should be formed with the express purpose of reviewing the protocols/procedures for each aspect of the overall medical readiness requirement for all Services. It is recommended this be accomplished for all services to establish DOD wide uniformity for all Reserve Components. As with the funding, uniformity in protocols and procedures should be accomplished at least within each Service.

4.4 SRA Team Conclusion

The SRA Team supports the following actions, as displayed in table 4-1.

Medical readiness support should be provided during the weekdays via the authorization of fragmentary annual training for the physical examinations and other medical readiness needs. Fragmentary annual training is suggested to avoid employer/employee problems; a change in current policy will be necessary.

Reserve Component medical readiness support should be provided by the Department of Veterans Affairs, through sharing agreement, for the following reasons:

- Cost per service is among the lowest available of all evaluated providers.
- The DVA has one of the highest accessibility percentages.
- The system is capable of satisfying all requirements for medical support, with its existing well-developed nationwide infrastructure.
- The DVA is interested in this mission, and is currently providing this support in some locations.

Table 4-1 RC 746 Study Matrix

	PROVIDER	ARNG		USAR		MTF		MEPS		ORK		DVA		CONTI	
RANKING	WEEKDAY/WEEKEND	WD	WE	WD	WE	WD	WE	WD	WE	WD	WE	WD	WE	WD	WE
						++		++		++		++		++	
1	ACCESSIBILITY														
2	COST							??							
3	SYSTEM IMPACT														
4	LOST TRAINING TIME														
5	OTHER COSTS	??		??											
6	EXPANSION					??	??								

= Strong Positive
= Positive
= Neutral or Middle Impact; Some Higher, Some Lower
= Negative
= Strong Negative
= Not a Reasonable Option or Not Applicable
?? = Unknown
++ = Requires an Extra AT Day and the Corresponding Funding Support

The SRA 746 Team listed the provider assessment criteria in the order (Ranking column), in their opinion, that h the greatest significance in the delivery of medical readiness support; other readers may elect to alter the order.

General review of each provider's cost, as determined by the study's methodology, concludes that the overall least expensive system for accomplishing medical readiness requirements, except for the annual dental examination, is the Active Component MTFs and Reserve Component unit examination sites. This conclusion was made after assuming that costs to operate USAR and ARNG examination sites are similar to Active Component MTFs. As the

ARNG TDA Medical Detachments accumulate all of the manpower, equipment, supply, administrative and other costs associated with their operation, the total cost versus other options may have to be further evaluated. The next least expensive would be sharing agreements with the Department of Veterans Affairs followed by civilian contracting. It should be noted that ORKAND Corporation and Continuum Healthcare, Inc., are also organizations that would be considered civilian contractors in any competitive bidding. The two organizations agreed to participate in the study and provide current rates for their services without regard to discounted CMAC rates. They, like other national level providers (Humana, Aetna, Foundation Health, etc) are reluctant to provide costs at which they would compete in any contract proposals. Their costs could be adjusted for volume of services provided and their extensive provider networks would be important in determining accessibility.

SECTION 5 RECOMMENDED OPTIONS

Scope of the Recommendation. The SRA 746 team is aware of related ongoing studies being led by DOD (HA) and (RA). Even though this study focuses on the Reserve Components of the Army, the SRA Team and the MEDCOM contract representatives recognize that there are at least three other perspectives that could be considered:

- A DOD wide perspective supported by DODMERB for total program uniformity, centralized budgeting, and consistency among the services,
- A DA wide perspective, to consider medical readiness support for both Reserve Components via a "blanket" Army program, and
- An Army plan that considers each Reserve Component independently based on its existing situation and resources.

The overall SRA 746 Team's recommendation can be adapted to any of these levels/degrees. The system changes necessary to support the recommendation must also be adapted to the appropriate level. For example, an evaluation of the existing clinical requirements should be accomplished at the highest level for consistency. The level/degree of effort will also dictate the responsible agencies for implementation and administration of the program. There are others that are beyond the scope of this study.

The SRA Team recommends the following system changes:

- Funding for medical readiness support to all service medical components should be centrally budgeted, distributed, and controlled. Further, capture the specific funding aspects for the RC medical readiness requirements for future program adjustments.

- A clinical panel should review the procedures and requirements currently in AR 40-501. The approved protocol for physical examinations and other medical readiness requirements should be made mandatory and consistent for all Reserve Components of the Army or DOD wide.

- RC Commanders must be responsible for ensuring that their unit personnel report for medical readiness support as scheduled, regardless of the source of support.

- Charge the AGR staff of the Regional Medical Command with the initial coordination and maintenance of the program for the Army.

- Document the current DODMERB program so that it can serve as a benchmark. Special consideration should be given to the Quality Assurance program, the extensive guidance provided to the direct care contract provider, and the advantage of having a single source provider for consistency, contract simplicity, singularity of guidance, and continuity of effort.

- Initiate efforts to change Title X, US Code to eliminate the periodic physical examination requirements for members under 30 years of age. The Active Component made this change in March of 1998. The standards for medical readiness requirements should be the same for all Components.

Recommendations.

The following, in order, are the SRA Team's recommendations for the three best systems for supporting RC medical readiness requirements.

1. *A conservative approach that addresses the most serious concerns and requires the minimum program change*. This pilot program would leave the ARNG system unaffected at present, remove responsibility for USAR medical readiness support from USAR RC medical units, and institute the following program for the USAR only:

- Medical readiness requirements to be satisfied during the week via fragmentary annual training, for all members of the Ready Reserve.
- Provision of medical readiness support under sharing agreements with the Department of Veterans Affairs because its costs are among the most competitive, its locations are highly accessible to RC units, and its facilities are already equipped and able to provide the full range of needed medical readiness support services. Further, its nationwide administrative infrastructure is in place, the DVA is interested in this mission, and the Department has experience working with RC via some existing sharing agreements.

When the pilot program has been in place long enough to generate sufficient program history, evaluate the ARNG and "NEW" USAR programs with respect to cost efficiency and ability to support. then make any necessary adjustments.

2. An Army-wide approach that addresses the overall concerns and provides the best solution to the provision of medical readiness support to the RC of the Army. This option removes all RC providers *and does not consider the state and community aspects of the current ARNG program.* This approach includes weekday medical readiness support provided by the Department of Veterans Affairs for the ARNG and the USAR. This initiative eliminates the need for peacetime resourcing of medical personnel, equipment and facilities within the Reserve Components. Being an "Army only" initiative, an RMC wide implementation program with the medical staff from the area STARCs, RSCs, and DVA supporting regions, is necessary. The MEDCOM RMC must take the lead. Initial implementation could start as a pilot program in one RMC.

3. A DOD-level initiative, involving the Reserve Component Elements of all the services. This option represents the most comprehensive program and the most difficult to implement. Being a joint undertaking, the DOD regions would have the lead. working with each Service medical element and each RC element within each service. This option does provide singularity in funding. procedural protocols, quality assurance, and direction. This initiative would require a major effort. but would be worth it in the long run. This approach might be viewed as the final step in an evolutionary process.

Alternate Options:

In the event additional options are desired. the SRA Team recommends medical readiness support be provided during the week and by a civilian provider having strong ratings in cost and accessibility criteria.

Note that those civilian providers not responding to this survey may be quite competitive in a bidding situation.

APPENDIX A

PLOTS OF CUSTOMER UNIT LOCATIONS WITH PROVIDER SITES OVERLAYS

APPENDIX A: PLOTS OF CUSTOMER UNIT LOCATIONS WITH PROVIDER SITES OVERLAYS

INDEX

Army National Guard Units

3,115 ARNG Units

United States Army Reserve Units

866 USAR Units

United States Army Reserve and Army National Guard Units

866 USAR and 3,115 ARNG Units

Orkand (Civilian) Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 2,702 / 3,115 x 100 = 86.74%

Orkand (Civilian) Providers versus USAR Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 776 / 866 x 100 = 89.61%

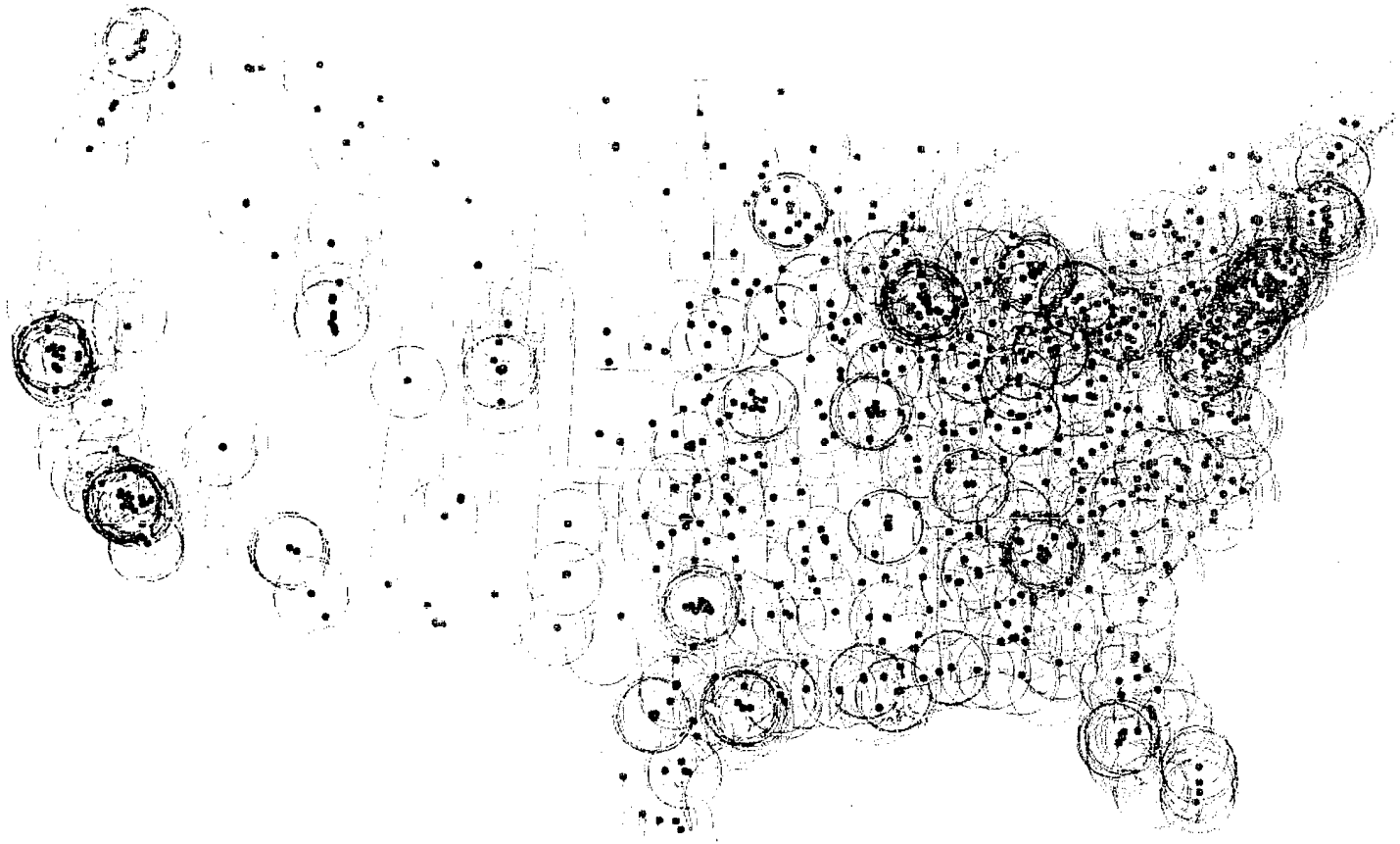
Orkand (Civilian) Providers versus All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 3,478 / 3,981 x 100 = 87.36%

Continuum Healthcare (Civilian) Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 3,021 / 3,115 x 100 = 96.98%

Continuum Healthcare (Civilian) Providers versus USAR Customers



Number of units within 75 mile radius / Number of units x 100 = % coverage = 854 / 866 x 100 = 98.61%

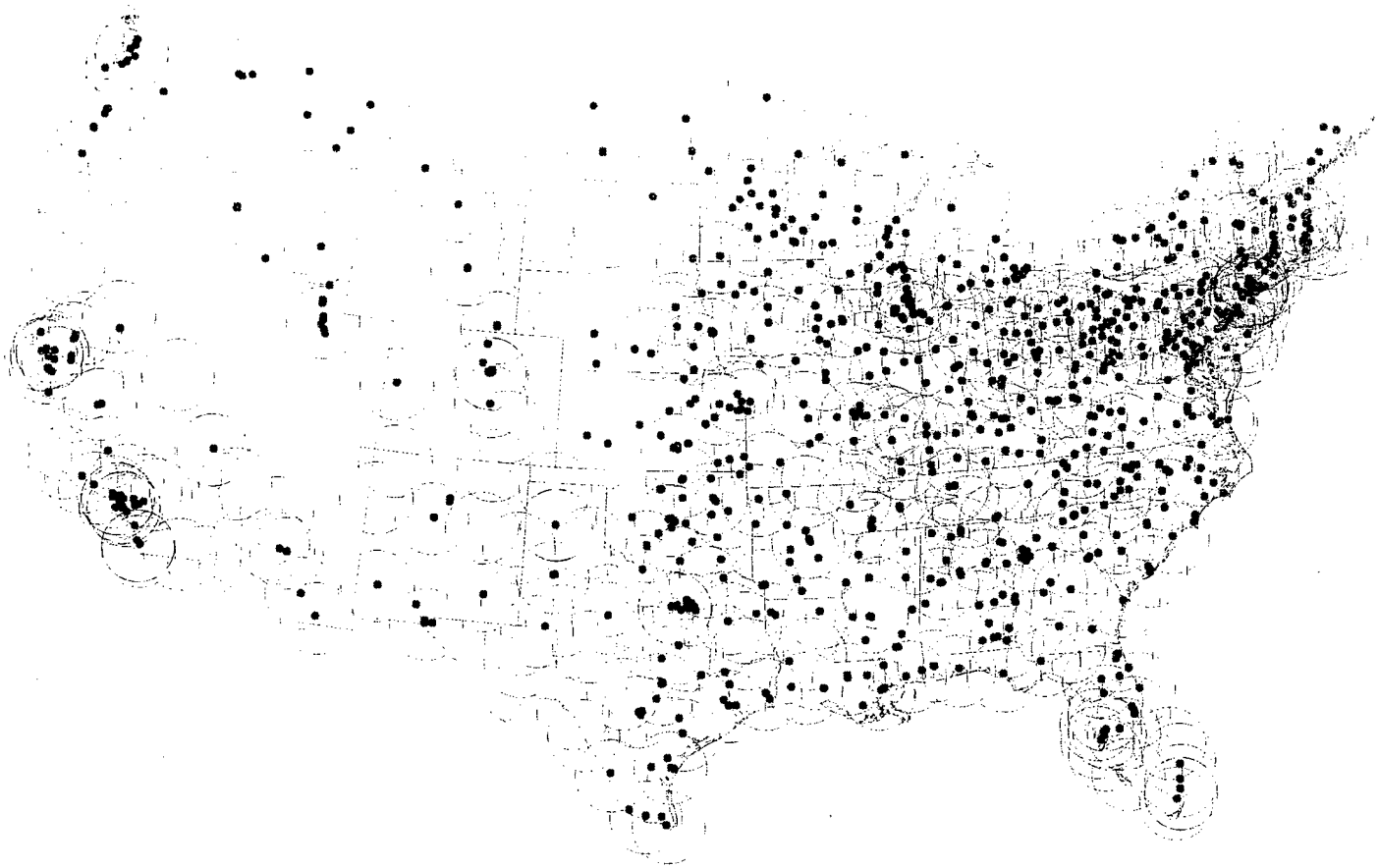
Continuum Healthcare (Civilian) Providers versus All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 3,875 / 3,981 x 100 = 97.34%

Department of Veterans Affairs Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 3,001 / 3,115 x 100 = 96.34%

Department of Veterans Affairs Providers versus USAR Customers



Number of units within 75 mile radius / Number of units x 100 = % coverage = 851 / 866 x 100 = 98.27%

Department of Veterans Affairs Providers versus All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 3,852 / 3,981 x 100 = 96.76%

Army Medical Treatment Facilities Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 638 / 3,115 x 100 = 20.48%

Army Medical Treatment Facilities Providers versus USAR Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 216 / 866 x 100 = 24.94%

Army Medical Treatment Facilities Providers versus All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 854 / 3,981 x 100 = 21.45%

Military Entrance Processing Stations (MEPS) Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 2,156 / 3,115 x 100 = 69.21%

Military Entrance Processing Stations (MEPS) Providers versus USAR Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 645 / 866 x 100 = 74.48%

Military Entrance Processing Stations Providers vs All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 2,801 / 3,981 x 100 = 70.36%

All Reserve Component Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 2,403 / 3,115 x 100 = 77.14%

All Reserve Component Providers versus USAR Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 704 / 866 x 100 = 81.29%

All Reserve Component Providers versus All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 3,195 / 3,981 x 100 = 80.26%

All ARNG Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 2,002 / 3,115 x 100 = 64.27%

All ARNG Providers versus USAR Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 527 / 866 x 100 = 60.85%

All ARNG Providers versus All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 2,737 / 3,981 x 100 = 68.75%

All TDA Reserve Component Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 2,058 / 3,115 x 100 = 66.07%

All TDA Reserve Component Providers versus USAR Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 580 / 866 x 100 = 66.97%

TDA Reserve Component Providers versus All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 2,803 / 3,981 x 100 = 70.41%

USAR TDA Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 615 / 3,115 x 100 = 19.74%

USAR TDA Providers versus USAR Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 242 / 866 x 100 = 27.94%

USAR TDA Providers versus All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 666 / 3,981 x 100 = 16.73%

All USAR Providers versus ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 1,150 / 3,115 x 100 = 36.92%

All USAR Providers versus USAR Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 532 / 866 x 100 = 61.43%

All USAR Providers versus All USAR / ARNG Customers

Number of units within 75 mile radius / Number of units x 100 = % coverage = 1,647 / 3,981 x 100 = 41.37%

APPENDIX B

PROVIDER COST COMPARISON

APPENDIX B: PROVIDER COST COMPARISON

INDEX

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99212

1 February 1998 Rates

FDME(Flight Physical) for Over 40 Years of Age: See NOTE 1 below.

Procedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212	$28.31	$26.89	$26.36	$25.07	$25.83	$26.39	$25.72	$28.44	$25.87	$28.04	$24.94	$26.82	$25.71
Clinical Examination - 2	99213													
Clinical Examination - 3	99203													
Dental Exam (NOTE 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947	$13.29	$11.48	$12.57	$11.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270	$9.97	$8.61	$9.43	$8.01	$8.21	$8.55	$8.73	$7.44	$11.05	$9.71	$8.77	$8.51	$7.90
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$253.47	$226.47	$233.19	$213.25	$217.48	$222.67	$222.56	$217.26	$246.41	$242.65	$220.69	$224.78	$213.15
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$281.80	$253.38	$258.95	$237.82	$242.77	$248.56	$247.69	$245.24	$272.07	$270.16	$245.19	$251.38	$238.53

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$227.23	$215.87	$204.51	$193.15	$181.79
Female Over 40 Years of Age	$253.35	$240.68	$228.01	$215.35	$202.68

NOTE 1: The procedures costed above assume a routine physical examination. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Average) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99213
1 February 1998 Rates

Over 40 Years of Age: See NOTE 1 below.

Procedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212													
Clinical Examination - 2	99213	$40.45	$38.43	$37.65	$35.85	$36.92	$37.71	$36.77	$40.52	$36.99	$39.97	$35.70	$38.34	$36.80
Clinical Examination - 3	99203													
Dental Exam (Note 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947	$13.29	$11.48	$12.57	$11.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270	$9.97	$8.61	$9.43	$8.01	$8.21	$8.55	$8.73	$7.44	$11.05	$9.71	$8.77	$8.51	$7.90
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$265.61	$238.01	$244.48	$224.03	$228.57	$233.99	$233.61	$229.34	$257.53	$254.58	$231.45	$236.30	$224.24
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$293.94	$264.92	$270.24	$248.60	$253.86	$259.88	$258.74	$257.32	$283.19	$282.09	$255.95	$262.90	$249.62

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$238.60	$226.67	$214.74	$202.81	$190.88
Female Over 40 Years of Age	$264.71	$251.48	$238.24	$225.00	$211.77

NOTE 1: The procedures costed above assume a routine physical. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Average) = $58.07. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99203
1 February 1998 Rates

Over 40 Years of Age: See NOTE 1 below.

Procedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212													
Clinical Examination - 2	99213													
Clinical Examination - 3	99203	$70.94	$67.50	$65.98	$63.08	$64.93	$66.23	$64.64	$70.35	$65.12	$69.59	$63.03	$67.36	$64.97
Dental Exam (Note 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947	$13.29	$11.48	$12.57	$11.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270	$9.97	$8.61	$9.43	$8.01	$8.21	$8.55	$8.73	$7.44	$11.05	$9.71	$8.77	$8.51	$7.90
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$296.10	$267.08	$272.81	$251.26	$256.58	$262.51	$261.48	$259.17	$285.66	$284.20	$258.78	$265.32	$252.41
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$324.43	$293.99	$298.57	$275.83	$281.87	$288.40	$286.61	$287.15	$311.32	$311.71	$283.28	$291.92	$277.79

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$267.18	$253.82	$240.46	$227.10	$213.75
Female Over 40 Years of Age	$293.30	$278.63	$263.97	$249.30	$234.64

NOTE 1: The procedures costed above assume a routine physical. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four Bitewing X-rays (ADA Code 00274) = $30.11. Total (National Median) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99212
1 February 1998 Rates

FDME(Flight Physical) for Under 40 Year of Age: See NOTE 1 below.

Proceedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212	$28.31	$26.89	$26.36	$25.07	$25.83	$26.39	$25.72	$28.44	$25.87	$28.04	$24.94	$26.82	$25.71
Clinical Examination - 2	99213													
Clinical Examination - 3	99203													
Dental Exam (NOTE 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947													
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270													
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$230.21	$206.38	$211.19	$193.57	$198.33	$202.72	$202.19	$199.90	$222.53	$219.99	$200.23	$204.93	$194.72
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$258.54	$233.29	$236.95	$218.14	$223.62	$228.61	$227.32	$227.88	$248.19	$247.50	$224.73	$231.53	$220.10

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$206.68	$186.02	$186.02	$175.68	$165.35
Female Over 40 Years of Age	$232.80	$221.16	$209.52	$197.88	$186.24

NOTE 1: The procedures costed above assume a routine physical examination. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Average) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99213
1 February 1998 Rates

Under 40 Years of Age: See NOTE 1 below.

Procedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212													
Clinical Examination - 2	99213	$40.45	$38.43	$37.65	$35.85	$36.92	$37.71	$36.77	$40.52	$36.99	$39.97	$35.70	$38.34	$36.80
Clinical Examination - 3	99203													
Dental Exam (Note 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000													
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947													
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270													
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$212.65	$189.85	$195.70	$179.17	$183.44	$187.28	$187.41	$181.78	$207.24	$202.54	$186.16	$188.88	$180.03
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$240.98	$216.76	$221.46	$203.74	$208.73	$213.17	$212.54	$209.76	$232.90	$230.05	$210.66	$215.48	$205.41

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Under 40 Years of Age	$190.93	$181.39	$171.84	$162.29	$152.75
Female Under 40 Years of Age	$217.05	$206.20	$195.34	$184.49	$173.64

NOTE 1: The procedures costed above assume a routine physical. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $$30.11. Total (National Average) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99203
1 February 1998 Rates

Under 40 Years of Age: See NOTE 1 below.

Procedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212													
Clinical Examination - 2	99213													
Clinical Examination - 3	99203	$70.94	$67.50	$65.98	$63.08	$64.93	$66.23	$64.64	$70.35	$65.12	$69.59	$63.03	$67.36	$64.97
Dental Exam (Note 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$13.00	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000													
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947													
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270													
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$243.14	$218.92	$224.03	$206.40	$211.45	$215.80	$215.28	$211.61	$235.37	$232.16	$174.87	$217.90	$208.20
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$271.47	$245.83	$249.79	$230.97	$236.74	$241.69	$240.41	$239.59	$261.03	$259.67	$199.37	$244.50	$233.58

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Under 40 Years of Age	$216.55	$205.72	$194.89	$184.07	$173.24
Female Under 40 Years of Age	$242.66	$230.53	$218.40	$206.26	$194.13

NOTE 1: The procedures costed above assume a routine physical. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing 1996 dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Median) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99212
1 February 1998 Rates

FDME(Flight Physical) for Under 40 Year of Age: See NOTE 1 below.

Proceedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212	$28.31	$26.89	$26.36	$25.07	$25.83	$26.39	$25.72	$28.44	$25.87	$28.04	$24.94	$26.82	$25.71
Clinical Examination - 2	99213													
Clinical Examination - 3	99203													
Dental Exam (NOTE 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947													
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270													
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$230.21	$206.38	$211.19	$193.57	$198.33	$202.72	$202.19	$199.90	$222.53	$219.99	$200.23	$204.93	$194.72
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$258.54	$233.29	$236.95	$218.14	$223.62	$228.61	$227.32	$227.88	$248.19	$247.50	$224.73	$231.53	$220.10

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$206.68	$186.02	$186.02	$175.68	$165.35
Female Over 40 Years of Age	$232.80	$221.16	$209.52	$197.88	$186.24

NOTE 1: The procedures costed above assume a routine physical examination. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Average) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99213
1 February 1998 Rates

FDME(Flight Physical) for Under 40 Year of Age: See NOTE 1 below.

Proceedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212													
Clinical Examination - 2	99213	$40.45	$38.43	$37.65	$35.85	$36.92	$37.71	$36.77	$40.52	$36.99	$39.97	$35.70	$38.34	$36.80
Clinical Examination - 3	99203													
Dental Exam (NOTE 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947													
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270													
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$242.35	$217.92	$222.48	$204.35	$209.42	$214.04	$213.24	$211.98	$233.65	$231.92	$210.99	$216.45	$205.81
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$270.68	$244.83	$248.24	$228.92	$234.71	$239.93	$238.37	$239.96	$259.31	$259.43	$235.49	$243.05	$231.19

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$218.05	$196.24	$196.24	$185.34	$174.44
Female Over 40 Years of Age	$244.16	$231.95	$219.75	$207.54	$195.33

NOTE 1: The procedures costed above assume a routine physical examination. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Average) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99203
1 February 1998 Rates

FDME(Flight Physical) for Under 40 Year of Age: See NOTE 1 below.

Proceedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212													
Clinical Examination - 2	99213													
Clinical Examination - 3	99203	$70.94	$67.50	$65.98	$63.08	$64.93	$66.23	$64.64	$70.35	$65.12	$69.59	$63.03	$67.36	$64.97
Dental Exam (NOTE 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947													
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270													
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$272.84	$246.99	$250.81	$231.58	$237.43	$242.56	$241.11	$241.81	$261.78	$261.54	$238.32	$245.47	#######
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$301.17	$273.90	$276.57	$256.15	$262.72	$268.45	$266.24	$269.79	$287.44	$289.05	$262.82	$272.07	#######

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$246.63	$221.97	$221.97	$209.64	$197.31
Female Over 40 Years of Age	$272.75	$259.11	$245.47	$231.84	$218.20

NOTE 1: The procedures costed above assume a routine physical examination. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Median) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99212

1 February 1998 Rates

FDME(Flight Physical) for Over 40 Years of Age: See NOTE 1 below.

Procedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212	$28.31	$26.89	$26.36	$25.07	$25.83	$26.39	$25.72	$28.44	$25.87	$28.04	$24.94	$26.82	$25.71
Clinical Examination - 2	99213													
Clinical Examination - 3	99203													
Dental Exam (NOTE 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947	$13.29	$11.48	$12.57	$11.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270	$9.97	$8.61	$9.43	$8.01	$8.21	$8.55	$8.73	$7.44	$11.05	$9.71	$8.77	$8.51	$7.90
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$253.47	$226.47	$233.19	$213.25	$217.48	$222.67	$222.56	$217.26	$246.41	$242.65	$220.69	$224.78	$213.15
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$281.80	$253.38	$258.95	$237.82	$242.77	$248.56	$247.69	$245.24	$272.07	$270.16	$245.19	$251.38	$238.53

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$227.23	$215.87	$204.51	$193.15	$181.79
Female Over 40 Years of Age	$253.35	$240.68	$228.01	$215.35	$202.68

NOTE 1: The procedures costed above assume a routine physical examination. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Average) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99213
1 February 1998 Rates

FDME(Flight Physical) for Over 40 Years of Age: See NOTE 1 below.

Procedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212													
Clinical Examination - 2	99213	$40.45	$38.43	$37.65	$35.85	$36.92	$37.71	$36.77	$40.52	$36.99	$39.97	$35.70	$38.34	$36.80
Clinical Examination - 3	99203													
Dental Exam (NOTE 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947	$13.29	$11.48	$12.57	$11.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
DNA Sample	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
Rectal with Guaiac	82270	$9.97	$8.61	$9.43	$8.01	$8.21	$8.55	$8.73	$7.44	$11.05	$9.71	$8.77	$8.51	$7.90
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$265.61	$238.01	$244.48	$224.03	$228.57	$233.99	$233.61	$229.34	$257.53	$254.58	$231.45	$236.30	$224.24
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$293.94	$264.92	$270.24	$248.60	$253.86	$259.88	$258.74	$257.32	$283.19	$282.09	$255.95	$262.90	$249.62

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$238.60	$226.67	$214.74	$202.81	$190.88
Female Over 40 Years of Age	$264.71	$251.48	$238.24	$225.00	$211.77

NOTE 1: The procedures costed above assume a routine physical examination. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Average) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

CMAC for Physical Examinations by State

Clinical Examination CPT Code 99203
1 February 1998 Rates

FDME(Flight Physical) for Over 40 Years of Age: See NOTE 1 below.

Procedure	CPT Code	Texas	Florida	Virginia	N Dakota	Utah	Penn	Tenn	Wash	Kansas	California	Miss	Ohio	Alabama
Clinical Examination - 1	99212													
Clinical Examination - 2	99213													
Clinical Examination - 3	99203	$70.94	$67.50	$65.98	$63.08	$64.93	$66.23	$64.64	$70.35	$65.12	$69.59	$63.03	$67.36	$64.97
Dental Exam (NOTE 2)	ADA Code	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62	$51.62
Audiogram	92551	$17.59	$16.59	$15.27	$14.32	$14.78	$15.31	$14.64	$17.72	$15.32	$17.09	$14.08	$16.04	$14.74
Electrocardiogram	93000	$29.70	$28.07	$26.78	$25.18	$25.98	$26.76	$25.83	$30.20	$26.41	$29.38	$24.83	$27.57	$25.78
CBC	85021	$13.96	$12.05	$13.20	$11.21	$12.28	$11.97	$12.22	$10.42	$13.47	$13.59	$12.28	$11.91	$11.06
Fasting Blood Sugar	82947	$13.29	$11.48	$12.57	$11.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HIV Test	86701	$39.88	$34.43	$37.72	$32.02	$32.83	$34.19	$34.92	$29.76	$38.48	$38.84	$35.07	$34.02	$31.59
Urinalysis	81000	$11.30	$9.76	$10.69	$9.07	$9.30	$9.69	$9.89	$8.43	$10.90	$11.00	$9.94	$9.64	$8.95
DNA Sample														
Rectal with Guaiac	82270	$9.97	$8.61	$9.43	$8.01	$8.21	$8.55	$8.73	$7.44	$11.05	$9.71	$8.77	$8.51	$7.90
HRA/CVSP														
Cholesterol	82465	$13.29	$11.48	$12.57	$10.67	$10.94	$11.40	$11.64	$9.92	$12.83	$12.95	$11.69	$11.34	$10.53
HDL(For HRA)	83718	$24.56	$15.49	$16.98	$14.41	$14.77	$15.39	$15.71	$13.39	$27.63	$17.48	$15.78	$15.97	$14.74
Total Required - Male		$296.10	$267.08	$272.81	$251.26	$256.58	$262.51	$261.48	$259.17	$285.66	$284.20	$258.78	$265.32	$252.41
Pelvic Exam(PAPS)	88141	$28.33	$26.91	$25.76	$24.57	$25.29	$25.89	$25.13	$27.98	$25.66	$27.51	$24.50	$26.60	$25.38
Total Required - Female		$324.43	$293.99	$298.57	$275.83	$281.87	$288.40	$286.61	$287.15	$311.32	$311.71	$283.28	$291.92	$277.79

		95%	90%	85%	80%
		(Discounted Average Costs)			
Thirteen State Average - Male Over 40 Years of Age	$267.18	$253.82	$240.46	$227.10	$213.75
Female Over 40 Years of Age	$293.30	$278.63	$263.97	$249.30	$234.64

NOTE 1: The procedures costed above assume a routine physical examination. No referrals or follow-up charges are included.

NOTE 2: Dental exam costs are derived from the annual national survey of prevailing dental fees by Dental Economics, May 1997 issue, adjusted 3.7% for 1997 and 1998. Periodic Oral Exam (ADA Code 00120) = $21.51. Four (4) Bitewing X-Rays (ADA Code 00274) = $30.11. Total (National Average) = $51.62. A panoramic film (ADA Code 00330) would add $58.07 to the cost.

APPENDIX C

SAMPLE SURVEY REPORTS

APPENDIX C: SAMPLE SURVEY REPORTS

INDEX

Request for information regarding the RC 746 Study

TYPE INFORMATION: Medical Provider
PRINCIPAL AGENCY: USAR
SOURCE: Provider Unit Level
CAPTURE METHOD: Electronic distributions direct to specific provider unit, if available.
ASSOCIATED STUDY FOCUS:

1.	Costs	x
2.	Accessibility	x
3.	Expansion Capability	x
4.	Impact on the System	x
5.	Training Time Loss	x
6.	Other Costs	x

USAR Medical Unit

Instructions: Please indicate the response that best fits your unit situation by placing your response in the appropriate area "( )" regarding the provision of physical examinations and other Reserve Component Medical Readiness services to unit members or individuals of the USAR or ARNG. Narrative comments are optional.

Section A: Unit Identification Information:

1. Unit Name, Address (with zip), and Unit Identification Code (UIC), Commercial telephone and fax numbers, and e-mail address, if available:

2. Strength.

   a. Direct care providers: Physicians, Nurse Practitioner, Physician Assistant)

   Authorized ( ) Assigned ( ).

3. Your unit type is:

   a. Table of Distribution and Allowances (TDA). ( )
   b. Table of Organization and Equipment (TOE/MTOE). ( )

c. Other (explain). ( )

Section B: Provider Information:

1. (Frequency) How many Unit Training Assemblies (UTA)/month are RC Medical Readiness Services provided by your unit ? (one UTA=4 hours; a weekend = 4 UTAs; example: working one site, every day, all day ,for 4 weekends a month = 16 UTAs)

(UTAs)

2. (Type Services and Magnitude) Your unit provides the following Reserve Component Medical Readiness services:

		Of those checked, average number per month:
Standard (5 year) Physical Examinations:	( )	( )
Flight Physicals:	( )	( )
Over 40 Screening:	( )	( )
Immunizations:	( )	( )
Eyewear prescription determination:	( )	( )
HIV testing	( )	( )
Other, please list:		
a.	( )	( )
b.	( )	( )

3. (Location) Your unit provides Reserve Component Medical Readiness services at the following location(s) or facilities:

( ) Unit assembly area (drill hall)
( ) A Department of Veterans Affairs facility (VA)
( ) A Military Entrance Procession Station (MEPS)
( ) An active duty military medical treatment facility (clinic or hospital)
( ) A civilian hospital
( ) An ARNG Clinic
( ) Other, please list ( )

If other than the Unit assembly area (drill hall), please list the name and address with zip code of the facility/facilities.

4. (Material) . What is the source of equipment used by your unit to provide medical readiness support?

( ) unit equipment (organic)
( ) equipment is owned by the facility used while providing medical support
( ) other, please explain below

REMARKS:

5. (Staffing) What is the average number of unit personnel engaged in the provision of all medical readiness services to RC units/individuals during IDT (weekend drills)?

Officers/WO (all grades): ( )
Enlisted (all grades): ( )

Note: This response must not consider time; the frequency and duration of the medical readiness support was provided in question #1.

6. (Full-time support) On the average, what is the total number of hours per month your full time administrative staff spend coordinating, scheduling, and processing the medical readiness work requirements?

( )

7. (Additional capability) Assuming there is no change in staff or equipment authorizations, if this were a directed priority for your unit, could your unit provide more medical readiness support than you are currently performing? ( )

a. If so, how much more (additional, not total) in terms of UTAs?
(UTAs)

Example: If you reported 4 UTAs in question 1 (or one weekend/month), but via RSTs you think your unit could do this every weekend if directed, you would respond with (12 UTAs).

b. Which factor below would be the limiting factor regarding your units' ability to expand medical readiness services to RC units?

( ) physician staff shortages
( ) support staff shortages
( ) facilities
( ) equipment
( ) other, please explain:

8. Does your unit use ATA, ADT, or sustain other costs such as transportation expenses, expendable supplies, etc. regarding your medical readiness support mission? If so, can you provide a monthly estimate (in terms of UTAs and/or dollars)?

9. If known, what is the longest distance traveled by members of a RC unit to receive medical readiness support from your unit?

(miles)

Section C: Subjective Remarks (Optional), **please reference a specific question:**

Request for information regarding the RC 746 Study

TYPE INFORMATION: Medical Provider
PRINCIPAL AGENCY: ARNG State Area Commands
SOURCE: Provider Unit Level
CAPTURE METHOD: Written survey mailed direct to STARC surgeons, for reproduction and distribution to medical readiness *providers units* within their command.
ASSOCIATED STUDY FOCUS:

7. Costs	x
8. Accessibility	x
9. Expansion Capability	x
10. Impact on the System	x
11. Training Time Loss	x
12. Other Costs	x

ARNG Medical Provider Unit Input:

Instructions: Please indicate the response that best fits your unit situation by placing your response in the appropriate area "( )" regarding the provision of physical examinations and other Reserve Component Medical Readiness services to unit members or individuals of the USAR or ARNG. Narrative comments are optional.

Section A: Unit Identification Information:

1. Unit Name. Address (with zip), and Unit Identification Code (UIC):

4. Strength

Direct Care Providers: Include all physicians. nurse practitioners. and physician assistants.

Authorized ( ) Assigned ( ) Excess* ( )

* Is excess due to unit transitional change yes ( ) No ( )

5. Your unit type is:

a. Table of Distribution and Allowances (TDA). ( )
b. Medical Table of Organization and Equipment (TOE/MTOE). ( )
c. Medical TOE/MTOE assets embedded in non-medical structure. ( )

Section B: Provider Information:

4. (Frequency / Duration) How many Unit Training Assemblies (UTA)/month are RC Medical Readiness Services provided by your unit? Example: working one site, all day, for one weekend (2 days) a month = 1 site x 2 UTA's/day x 2 days = 4 UTAs/month

(UTAs)

5. (Type Services and Magnitude) Your unit provides the following Reserve Component Medical Readiness services:

	Check if yes	Average number per month
Standard (5 year) Physical Examinations:	( )	( )
Under 40		( )
Over 40		( )
Flight Physicals:	( )	( )
Immunizations:	( )	( )
Eyewear prescription determination:	( )	( )
HIV testing	( )	( )
DNA sampling	( )	( )
Other, please list:		
a.	( )	( )
b.	( )	( )

6. (Location) Your unit provides Reserve Component Medical Readiness services at the following location(s) or facilities:

( ) Unit assembly area (drill hall)
( ) A Department of Veterans Affairs facility (VA)
( ) A Military Entrance Processing Station (MEPS)
( ) An active duty military medical treatment facility (clinic or hospital)
( ) A civilian hospital
( ) An ARNG Clinic
( ) Other, please list ( )

If other than the Unit assembly area (drill hall), please list the name and address with zipcode of the facility/facilities.

4. (Material) What is the source of equipment used by your unit to provide medical readiness support?

( ) unit equipment (organic)
( ) equipment is owned by the facility used while providing the medical support
( ) other, please explain below

5. (Staffing) What is the average number of unit personnel engaged in the provision of all medical readiness services to RC units/individuals during IDT (weekend drills)?

Officers/WO (all grades): ( )
Enlisted (all grades): ( )

Note: This response must not consider time; the frequency and duration of the medical readiness support was provided in question #1.

6. (Full-time support) On the average, what is the total number of hours per month your full time administrative staff spend coordinating, scheduling, and processing the medical readiness work requirements?

( )

7. (Capability) Assuming there is no change in staff or equipment authorizations, ***if*** this were a directed priority for your unit, could your unit provide more medical readiness support than you are currently performing? yes ( ) no ( )

c. If so, how much more (additional, not total) in terms of UTAs?
(UTAs)

Example: If you reported 4 UTAs in question 1 (or one weekend/month), but via RSTs you think your unit could do this every weekend if directed, you would respond with (**12 UTAs**): 4 (currently) + **12 (additional).**

d. Which factor below would be the limiting factor regarding your units' ability to expand medical readiness services to RC units?

( ) physician staff shortages
( ) support staff shortages
( ) facilities
( ) equipment
( ) other. please explain:

8. Does your unit use ATA, ADT, or sustain other costs such as transportation expenses, expendable supplies, etc. regarding your medical readiness support mission? If so, can you provide a monthly estimate (in terms of UTAs and/or dollars)?

9. If known, what is the longest distance traveled by members of a RC unit to receive medical readiness support from your unit?

(miles)

Section C: Subjective Remarks (Optional), **please reference a specific question:**

RESERVE COMPONENT 746 STUDY

SURVEY TYPE: PROVIDER
SOURCE: USAMEDCOM, REGIONAL MEDICAL COMMANDS
SURVEY TOPICS FOR CONSIDERATION:

COST	X
ACCESSIBILITY	X
EXPANSION CAPABILITY	X
IMPACT ON THE SYSTEM (RC ONLY)	
LOSS OF TRAINING TIME (RC ONLY)	
ADDITIONAL COSTS (RC ONLY)	

Instructions: Please complete return to SRA POC below via mail, email or fax at the following addresses:
Mail: SRA International, Inc, ATTN: Don Anderson, 1777 N.E. Loop 410, Suite 510, San Antonio, TX 78217
Email: don_anderson@sra.com
Fax: (210) 824-9578
Questions: please call: (210) 832-5222

Request the completed information be returned to SRA by 31 Dec 97.

1. Administrative Information:

RMC completing this survey:

Name and telephone number of the primary POC or individual completing this survey:

2. Study Information:

a. (Possible facilities) How many major subordinate medical commands (MEDCENs and MEDDACs) are in your RMC?

b. (Degree of support) How many of these commands provide the 5-year retention Physical Examinations to members of the Reserve Components on an on going basis.

c. (Current level of support/ by component/P.E. site location) Please list those MEDCENs/MEDDACs that are providing Physical Examinations and, under each, indicate the zip code(s) of the Physical Exam site (s), followed by the average number of Physical Exams performed at each site, per month, and breakout by RC component, if available. Please report Reserve Component Physicals Only!

Example:	MTF	PE Site ZIP Code	PE/month	ARNG	USAR	Other RC
	ZAMC:					
		84592	15	3	12	0
		84440	10	4	5	1

d. (Cost information) Based on the best Resource Management Information available what is the average cost for the Reserve Component Physical Examinations at the MTFs in your command. If you wish you may break the figure into the standard retention PE and the Phase II (over 40) PE, which will have additional cardiovascular screening procedures and consequently be more expensive. We request you provide the very best estimate of costs, if specific RM data is not available, specifically for the Reserve Component Physicals.

e. (Expansion Capability) If directed by higher headquarters, considering all current sites being operated in your command, how many Reserve Component Physicals could you perform during the month?

f. Subjective Remarks / Explanation / Response Clarification (Please reference specific question as appropriate).

Reserve Component 746 Study **RC Command:** _____

Source: STARC and Regional Support Commands

Topic: **Direct Costs** incurred or programmed for the provision of Medical Readiness Support

Please pass this request for cost information to the Resource Management element of your headquarters. if necessary.

This request is being completed by many different organizations. There will probably be many ways the needed information is maintained or programmed. Please provide sufficient narrative information or remarks to ensure the proper interpretation of the information provided. Historical costs or programmed costs may be provided. **Please choose the information that will provide the best and true picture, for your command**, regarding costs for the provision of Medical Readiness Support Services and indicate which is being provided.

In order to capture the over all cost in the provision of Medical Readiness Services to the Reserve Components. request the following information be provided.

1. Costs.

a. How many dollars were spent during FY 97 in support of medical readiness operations for soldiers in your command?

b. How many dollars are budgeted in FY 98 in support of medical readiness operations for soldiers in your command?

2. What is the total troop strength in your command?

3. How much was spent in **contracts for services**:

   For facilities _____

   For physical examinations _____

   For dental examinations _____

   For other _____

If this data if further broken down into sub-categories please show them. for better interpretation of information provided.

4. How was this budgeted or programmed amount determined?

   a. Historically (base on the amount spent in past years) _____.

   b. Based on 20 percent of the total force supported (5 year physical exam, with weighted factors for phase II (over forty/flight physicals) and historical date for immunizations and other medical readiness services. _____.

   c. Other. Please explain.

5. What is the **average** cost (excluding staffing costs) per individual, for:

   Normal 5 year physical examination _____.
   Phase II / Over 40 physical _____
   Flight Physical _____
   Annual Dental Exam_____
   Immunizations _____
   DNA Sampling _____
   HIV testing _____
   Annual certification of physical condition _____
   Other _____

Please return this completed survey via one of the following means:

Mail (Registered please):

SRA International Inc.
ATTN: Don Anderson
1777 N.E. Loop 410, Suite 510
San Antonio. TX 78217

Fax: (210) 824-9578

Email: don_anderson@sra.com

Questions: (210) 832-5222

Interview Topics:

Note: Define the Medical Readiness Requirements, for this study, as: Physical examinations, Dental examinations, Eye examinations, Immunizations, and HIV Testing

1. ***When and how are your units obtaining medical readiness support presently?***

   Estimate the percentage of each of the following.

   WHEN:
   ____ During IDT weekends
   ____ during AT
   ____ other specify

   HOW:
   _____ from RC medical personnel
   _____ in a VA facility
   _____ in a MEPS facility
   _____ at the drill hall
   _____ from the VA (**their staff and facility**)
   _____ from a MEPS, (**their staff and facility)**
   _____ through a contracted civilian agency

REMARKS:

2. ***From your experience and perspective, what are the most serious problems for your units regarding meeting their medical readiness requirements?***

   ____ Loss of training time
   ____ General disruption with unit activities
   _____ Cost
   _____ Accessibility of medical equipment
   _____ Accessibility of the medical support
   _____ Medical readiness requirements are ignored (there is just not enough time for it)

REMARKS:

3. ***From your experience and perspective, what is the best solution to the problem of your units meeting their medical readiness requirements?***

   Under the current parameters,
   _____ Local contract
   _____ Nearest federal provider (AMEDD MTF, MEPCOM, DVA)
   _____ Other

   When
   ____ IDT
   ____ AT

   "Outside the box"

4. ***Do you support a greater effort by all medical RC units in the provision of medical readiness requirements (all RC medical units operating sites during multiple IDT weekends and perhaps at multiple site locations)?***

_____TOE (MTOE) and TDA units?
_____TDA only
_____No, not our mission!

REMARKS:

APPENDIX D

ACRONYMS

APPENDIX D: ACRONYMS

AC ..... Active Component
ADA Codes ..... American Dental Association Codes
AFIP ..... Armed Forces Institute of Pathology
AGR ..... Active Guard Reserve
ARNG ..... Army National Guard; COMPO 2
AR PERSCOM ..... Army Reserve Personnel Command
ASI ..... Additional Skill Identifier
ATRRS ..... Army Training Requirements and Resources System
BAMC ..... Brooke Army Medical Center
CBC ..... Complete Blood Count
CDT-2 Codes ..... Current Dental Terminology Codes
CHAMPUS ..... Civilian Health and Medical Program for Uniformed services
CMAC ..... CHAMPUS Maximum Allowable Charge
COMPO 1 ..... Component 1 (Active Army)
COMPO 2 ..... Component 2 (Army National Guard)
COMPO 3 ..... Component 3 (United States Army Reserve)
CPT Codes ..... Current Procedural Terminology Codes
CVSP ..... Cardiovascular Screening Program
DE ..... Dental Examination
DMDC ..... Defense Manpower Data Center
DNA ..... Deoxyribonucleic Acid
DOD ..... Department of Defense
DOD (HA) ..... Department of Defense, Health Affairs
DOD (RA) ..... Department of Defense, Reserve Affairs
DODMERB ..... Department of Defense Medical Examination and Review Board
DVA ..... Department of Veterans Affairs
ELISA ..... Enzyme–linked immunoabsorbent assay
FDME ..... Flying Duty Medical Examination
FSP ..... Force Support Package
G-6-PD ..... Glucose Phosphate Dehydrogenase
HCT ..... Hematocrit
HDL ..... High Density Lipoprotein
HGB ..... Hemoglobin
HIV ..... Human Immunovirus
HMO ..... Health Maintenance Organization
HRA ..... Health Readiness Assessment
IGCE ..... Independent Government Cost Estimate
IOP ..... Intraocular Pressure
LDL ..... Low Density Lipoprotein
MEPRS ..... Medical Expense and Performance Reporting System
MFF ..... Military Freefall
MEDCOM ..... Medical Command

MEPS ..... Military Entrance Processing Station
MOS ..... Military Occupational Specialty
MTF ..... Medical treatment facility
MTOE ..... Modified Table of Organization and Equipment
NGB ..... National Guard Bureau
ORKAND ..... ORKAND Corporation
OTSG ..... Office of the Surgeon General
PE ..... Physical Examination
POC ..... Point of Contact
QA ..... Quality Assurance
RC ..... Reserve Component
RMC ..... Regional Medical Command
RSC ..... Regional Support Command
SERE ..... Search, Evasion, Resistance and Escape
SF ..... Special Forces
SRA ..... Systems Research and Applications Corporation
SRTS ..... Spectacle Request Transmission System
STARC ..... State Area Command
TAG ..... The Adjutant General
TDA ..... Table of Distribution and Allowances
TITLE X ..... Title X, United States Code
TRICARE ..... Contracted healthcare program for family members and retirees
TSRDIP ..... The Selected Reserve Dental Insurance Program
USAAMC ..... United States Army Aeromedical Center
USAMEDCOM ..... United States Army Medical Command
USAR ..... United States Army Reserve
USARC ..... United States Army Reserve Command
WARTRACE ..... Wartime Command and Control Relationships